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111TH CONGRESS
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REPT. 111–299
Part 2

AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 3200

together with

DISSENTING AND ADDITIONAL VIEWS

OCTOBER 14, 2009.—Ordered to be printed

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AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

OCTOBER 14, 2009.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. RANGEL, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING AND ADDITIONAL VIEWS

[To accompany H.R. 3200]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3200) to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause (other than title VII of division B and division C) and insert the following:

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

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

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

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS
Subtitle A—General Standards
Subtitle B—Standards Guaranteeing Access to Affordable Coverage
Subtitle C—Standards Guaranteeing Access to Essential Benefits
Subtitle D—Additional Consumer Protections
Subtitle E—Governance
Subtitle F—Relation to other requirements; Miscellaneous
Subtitle G—Early Investments
TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS
Subtitle A—Health Insurance Exchange
Subtitle B—Public health insurance option
Subtitle C—Individual Affordability Credits
TITLE III—SHARED RESPONSIBILITY
Subtitle A—Individual responsibility

Subtitle B—Employer Responsibility
TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986
Subtitle A—Shared responsibility
Subtitle B—Credit for small business employee health coverage expenses
Subtitle C—Disclosures to carry out health insurance exchange subsidies
Subtitle D—Other revenue provisions

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE
Subtitle A—Provisions related to Medicare part A
Subtitle B—Provisions Related to Part B
Subtitle C—Provisions Related to Medicare Parts A and B
Subtitle D—Medicare Advantage Reforms
Subtitle E—Improvements to Medicare Part D
Subtitle F—Medicare Rural Access Protections
TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS
Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries
Subtitle B—Reducing Health Disparities
Subtitle C—Miscellaneous Improvements
TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE
TITLE IV—QUALITY
Subtitle A—Comparative Effectiveness Research
Subtitle B—Nursing Home Transparency
Subtitle C—Quality Measurements
Subtitle D—Physician Payments Sunshine Provision
Subtitle E—Public Reporting on Health Care-Associated Infections
TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION
TITLE VI—PROGRAM INTEGRITY
Subtitle A—Increased funding to fight waste, fraud, and abuse
Subtitle B—Enhanced penalties for fraud and abuse
Subtitle C—Enhanced Program and Provider Protections
Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse
TITLE VII—MEDICAID AND CHIP
Subtitle A—Medicaid and Health Reform
Subtitle B—Prevention
Subtitle C—Access
Subtitle D—Coverage
Subtitle E—Financing
Subtitle F—Waste, Fraud, and Abuse
Subtitle G—Puerto Rico and the Territories
Subtitle H—Miscellaneous
TITLE VIII—REVENUE-RELATED PROVISIONS
TITLE IX—MISCELLANEOUS PROVISIONS

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

TITLE I—COMMUNITY HEALTH CENTERS
TITLE II—WORKFORCE
Subtitle A—Primary care workforce
Subtitle B—Nursing workforce
Subtitle C—Public Health Workforce
Subtitle D—Adapting workforce to evolving health system needs
TITLE III—PREVENTION AND WELLNESS
TITLE IV—QUALITY AND SURVEILLANCE
TITLE V—OTHER PROVISIONS
Subtitle A—Drug discount for rural and other hospitals
Subtitle B—School-Based health clinics
Subtitle C—National medical device registry
Subtitle D—Grants for comprehensive programs To provide education to nurses and create a pipeline to nursing
Subtitle E—States failing To adhere to certain employment obligations

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

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

(a) PURPOSE.—

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

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

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

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

(C) includes sliding scale affordability credits; and

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

so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending

so that health care becomes more affordable for businesses, families, and government.

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

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

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

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

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

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

Subtitle C—Standards Guaranteeing Access to Essential Benefits

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

Subtitle D—Additional Consumer Protections

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

Subtitle E—Governance

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

Subtitle F—Relation to Other Requirements; Miscellaneous

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

Subtitle G—Early Investments

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

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

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

Subtitle B—Public Health Insurance Option

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

Subtitle C—Individual Affordability Credits

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

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Sec. 301. Individual responsibility.

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

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

PART 2—EMPLOYER RESPONSIBILITY

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

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

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

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

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

Subtitle D—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

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

PART 2—PREVENTION OF TAX AVOIDANCE

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

PART 3—PARITY IN HEALTH BENEFITS

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

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

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

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

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

(4) COST-SHARING.—The term "cost-sharing" includes deductibles, coinsurance, copayments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.

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

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

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

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

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

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

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

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

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

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

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

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

(13) HEALTH INSURANCE EXCHANGE.—The term "Health Insurance Exchange" means the Health Insurance Exchange established under section 201.

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

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

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

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

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

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

(18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms "premium plan" and "premium-plus plan" have the meanings given such terms in section 203(c).

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

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

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

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

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

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

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

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

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

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

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

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

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

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

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

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

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

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

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

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

(c) TERMINOLOGY.—In this division:

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

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

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

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

(1) LIMITATION ON NEW ENROLLMENT.—

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

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

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

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

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

(1) GRACE PERIOD.—

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

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

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

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

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

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

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

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

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

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

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any pre-existing condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any health status-related factors (as defined in section 2791(d)(9) of the Public Health Service Act) in relation to the individual or dependent.

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

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

SEC. 113. INSURANCE RATING RULES.

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

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

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

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

(b) STUDY AND REPORTS.—

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

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

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

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

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

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

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

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

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

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

SEC. 115. ENSURING ADEQUACY OF PROVIDER NETWORKS.

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

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

SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.

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

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

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

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

(b) CHOICE OF COVERAGE.—

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

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

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

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

SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term "essential benefits package" means health benefits coverage, consistent with standards adopted under section 124 to ensure the provision of quality health care and financial security, that—

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

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

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

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

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

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

(1) Hospitalization.

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

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

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

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services.

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

(9) Maternity care.

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

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

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for preventive items and services (as specified under the benefit standards), including well baby and well child care.

(2) ANNUAL LIMITATION.—

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

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

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

(3) MINIMUM ACTUARIAL VALUE.—

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

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

SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, consumer representatives, employers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in care for those with disabilities, representatives of relevant governmental agencies. and at least one practicing physician or other health professional and an expert on children's health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

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

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

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

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

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

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

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

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

(B) PREMIUM PLAN.—The level of cost-sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(c) OPERATIONS.—

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

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

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

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

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

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

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

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

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

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

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

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

(b) ADOPTION OF STANDARDS.—

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

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

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

Subtitle D—Additional Consumer Protections

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

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

SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

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

(b) INTERNAL CLAIMS AND APPEALS PROCESS.—Under a qualified health benefits plan the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update such process in accordance with any standards that the Commissioner may establish.

(c) EXTERNAL REVIEW PROCESS.—

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

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

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

SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) IN GENERAL.—A qualified health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner. The Commissioner shall require that such disclosure be provided in plain language.

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

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

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

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

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

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

SEC. 135. TIMELY PAYMENT OF CLAIMS.

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

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

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

SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

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

Subtitle E—Governance

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

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

(b) COMMISSIONER.—

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

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

SEC. 142. DUTIES AND AUTHORITY OF COMMISSIONER.

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

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

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

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

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

(b) PROMOTING ACCOUNTABILITY.—

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

(2) COMPLIANCE EXAMINATION AND AUDITS.—

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

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

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

(d) SANCTIONS AUTHORITY.—

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

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

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

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph

(1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

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

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

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

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 208 and 241(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 143. CONSULTATION AND COORDINATION.

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

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

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

(3) Other appropriate Federal agencies.

(4) Indian tribes and tribal organizations.

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

(b) COORDINATION.—

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

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

SEC. 144. HEALTH INSURANCE OMBUDSMAN.

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

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

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

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

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

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

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

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

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

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 151. RELATION TO OTHER REQUIREMENTS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

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

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

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

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

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

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

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

SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.

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

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

SEC. 153. WHISTLEBLOWER PROTECTION.

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

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

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

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

(4) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to

be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act.

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

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

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

SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

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

SEC. 155. SEVERABILITY.

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

Subtitle G—Early Investments

SEC. 161. ENSURING VALUE AND LOWER PREMIUMS.

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

"SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.

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

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

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

"SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

"The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the same manner as such provisions apply to health insurance coverage offered in the small or large group market.".

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

SEC. 162. ENDING HEALTH INSURANCE RESCISSION ABUSE.

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

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

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

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

"(f) RESCISSION.—A health insurance issuer may rescind health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2). The Secretary, no later than July 1, 2010, shall issue guidance implementing this requirement, including procedures for independent, external third party review.".

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

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

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

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply on and after October 1, 2010, with respect to health insurance coverage issued before, on, or after such date.

SEC. 163. ADMINISTRATIVE SIMPLIFICATION.

(a) STANDARDIZING ELECTRONIC ADMINISTRATIVE TRANSACTIONS.—

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

"SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(2) protected from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 164. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

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

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

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

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

(ii) provides health benefits to retirees.

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

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

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

(i) is 55 years of age or older;

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

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

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

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

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

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

(B) BASIS FOR CLAIMS.—Each claim submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the appropriate employment based health benefits provided to a retiree or to the spouse, surviving spouse, or dependent of a retiree. In determining the amount of any claim for purposes of this subsection, the participating employment-based plan

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

(2) PROGRAM PAYMENTS AND LIMIT.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceeds $15,000, but is less than $90,000. Such amounts shall be adjusted each year based on the percentage increase in the medical care component of the Consumer Price Index (rounded to the nearest multiple of $1,000) for the year involved.

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

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

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

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

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

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

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

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

(C) APPROPRIATIONS FROM THE TRUST FUND.—

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

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

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

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

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

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

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

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

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

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

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

SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

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

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term "Exchange-eligible individual" means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

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

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

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

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

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

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

(2) SECOND YEAR.—In Y2—

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

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

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

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

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

(d) INDIVIDUALS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) CONTINUING ELIGIBILITY PERMITTED.—

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

(B) EXCEPTIONS.—

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

(I) under part A of the Medicare program;

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

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

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

(e) EMPLOYERS.—

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

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

(3) LARGER EMPLOYERS.—

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

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

(4) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement of section 311(a) through paragraph (1) of such section by offering a group health plan and not through offering an Exchange-participating health benefits plan.

(5) EMPLOYER PARTICIPATION AND CONTRIBUTIONS.—

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

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

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

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

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

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

(h) EXCHANGE ACCESS STUDY.—

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

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

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

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

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress on the study conducted under this subsection and shall include in such report recommendations regarding changes in standards for Exchange eligibility for individuals and employers.

SEC. 203. BENEFITS PACKAGE LEVELS.

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

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

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

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

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

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

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

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

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

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

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

(2) BASIC PLAN.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall contract for outpatient services with covered entities (as defined in section 340B(a)(4) of the Public Health Service Act, as in effect as of July 1, 2009). The Commissioner shall specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act.

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

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

(c) CONTRACTS.—

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

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

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

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

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

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

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

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

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

(C) TERMINATION.—

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

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

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

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

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of title I with respect to an entity for a violation of such a requirement.

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

(a) IN GENERAL.—

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

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

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such

process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

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

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

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

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

(iv) experiences a significant change in income.

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

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

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

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

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

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

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

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

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) and who does not otherwise enroll in another Exchange-participating health benefits plan.

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

(c) COVERAGE INFORMATION AND ASSISTANCE.—

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

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

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet website through which individuals may obtain information on coverage under Exchange-participating health benefits plans and file complaints;

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

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

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

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

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

(1) COVERAGE FOR CERTAIN NEWBORNS.—

(A) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, for the period of time beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

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

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

(B) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in subparagraph (A) who at the end of the period referred to in such subparagraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(c)(1) of the Social Security Act) to be a traditional Medicaid eligible individual described in section 1902(l)(1)(B) of such Act.

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

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

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

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—

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

(B) MEDICAID ENROLLMENT OBLIGATION.—An Exchange eligible individual may apply, in the manner described in section 241(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4). In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

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

(3) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State (each in this division referred to as a "Medicaid memorandum of un-

derstanding") with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State's Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State Medicaid plan.

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

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

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

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

(ii) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

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

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

SEC. 206. OTHER FUNCTIONS.

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

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

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

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

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

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

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

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

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

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

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

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

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

SEC. 207. HEALTH INSURANCE EXCHANGE TRUST FUND.

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

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

(c) TRANSFERS TO TRUST FUND.—

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

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

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

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

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b) plus such amounts as are necessary reduced by the amounts deposited under paragraph (1).

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

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

(a) IN GENERAL.—If—

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

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

(b) REQUIREMENTS FOR APPROVAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

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

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

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

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

(D) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Government which does exceed the cost to the Federal Government if this section did not apply; and

(E) enforcement activities consistent with federal requirements.

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

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

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

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

(c) CEASING OPERATION.—

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

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

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

(d) RETENTION OF AUTHORITY.—

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

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

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

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

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

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

Subtitle B—Public Health Insurance Option

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

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

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

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

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

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

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

(B) may offer premium-plus plans.

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

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

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

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

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

SEC. 222. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

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

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

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

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

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

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

(b) ACCOUNT.—

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

(2) START-UP FUNDING.—

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

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

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) RATES ESTABLISHED BY SECRETARY.—

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

(2) INITIAL PAYMENT RULES.—

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

(B) EXCEPTIONS.—

(i) PRACTITIONERS' SERVICES.—Payment rates for practitioners' services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this paragraph shall be not less than 1 percent.

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

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

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

(b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(1) INITIAL INCENTIVE PERIOD.—

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

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

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

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

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

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

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

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

(f) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 224.

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

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

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

(1) seeks to—

(A) improve health outcomes;

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

(C) provide efficient and affordable care;

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

(E) prevent or manage chronic illness; and

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

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

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

SEC. 225. PROVIDER PARTICIPATION.

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

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

(c) PAYMENT TERMS FOR PROVIDERS.—

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

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

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

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

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

SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

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

Subtitle C—Individual Affordability Credits

SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

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

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

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

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

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

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle. The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

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

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

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

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

(c) USE OF AFFORDABILITY CREDITS.—

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

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

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

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

SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term "affordable credit eligible individual" means, subject to subsection (b), an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 312;

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

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

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

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

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

(2) EXCEPTIONS.—

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

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

(c) INCOME DEFINED.—

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

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

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

SEC. 243. AFFORDABILITY PREMIUM CREDIT.

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

(b) AFFORDABLE PREMIUM AMOUNT.—

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

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

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

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

initial premium percentage to the final premium percentage specified in such table for such income tier.

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

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

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

In the case of family income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	The actuarial value percentage is—
133% through 150%	1.5%	3%	97%
150% through 200%	3%	5%	93%
200% through 250%	5%	7%	85%
250% through 300%	7%	9%	78%
300% through 350%	9%	10%	72%
350% through 400%	10%	11%	70%

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

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

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

SEC. 244. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's family income.

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

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

SEC. 245. INCOME DETERMINATIONS.

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

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

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

(2) INCOME VERIFICATION.—

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

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

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

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

(c) SPECIAL RULES.—

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

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

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

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

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

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

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

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

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 301. INDIVIDUAL RESPONSIBILITY.

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

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 102(b))) in accordance with section 312.

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

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

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

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

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 311(1) either through an Exchange-participating health benefits plan or other than through such a plan.

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

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

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

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

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986) under a qualified health benefits plan (or current employment-based health plan) is equal to—

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

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

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

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution under this subsection with respect to a full-time employee that reflects the proportion of—

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

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

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

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

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll such employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

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

(3) NOTICE REQUIREMENTS.—

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

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

SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

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

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

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

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

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

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

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

(3) ANNUAL PAYROLL.—For purposes of this paragraph, the term "annual payroll" means, with respect to any employer for any calendar year, the aggregate wages paid by the employer during such calendar year.

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

SEC. 314. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury)

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

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

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

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

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

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

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

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

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

"(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

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

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

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

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

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

"(1) separate lines of business, and

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

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

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

"SEC. 806. REGULATIONS.

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

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

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

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

"(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

"(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

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

"(C) LIMITATIONS ON AMOUNT OF PENALTY.—

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

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

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

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

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

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

"(II) $500,000.

"(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

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

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

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 734 the following new items:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"Sec. 801. Election of employer to be subject to national health coverage participation requirements.

"Sec. 802. Treatment of coverage resulting from election.
"Sec. 803. Health coverage participation requirements.
"Sec. 804. Rules for applying requirements.
"Sec. 805. Termination of election in cases of substantial noncompliance.
"Sec. 806. Regulations.".

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

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

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

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

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

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

"SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

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

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

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

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

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

"(A) such election shall be treated as the establishment and maintenance of a group health plan for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

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

"(2) PERIODIC INVESTIGATIONS TO DETERMINE COMPLIANCE WITH HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—The Secretary shall regularly audit a representative sampling of employers and conduct investigations and other activities with respect to such sampling of employers so as to discover noncompliance with the health coverage participation requirements in connection with such employers (during any period with respect to which an election under subsection (a) is in effect). The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

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

"(d) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under subsection (a) with respect to full-time employees and employees who are not full-time employees.

"(e) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under subsection (a) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

"(f) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

"(1) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

"(2) LIMITATIONS ON AMOUNT OF PENALTY.—

"(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under paragraph (1) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under paragraph (1) with respect to any failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

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

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

"(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

"(ii) $500,000.

"(3) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under paragraph (1) with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

"(4) ACTIONS TO ENFORCE ASSESSMENTS.—The Secretary may bring a civil action in any District Court of the United States to collect any civil penalty under this subsection.

"(5) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under paragraph (1) in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

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

"(g) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this section, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this section.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to periods beginning after December 31, 2012.

SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

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

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

(b) MULTIEMPLOYER PLANS.—In the case of a group health plan that is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the regulations prescribed in accordance with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing sponsors of such plan.

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

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

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

"PART VIII—HEALTH CARE RELATED TAXES

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

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

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

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

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

"(1) the taxpayer's modified adjusted gross income for the taxable year, over

"(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

"(b) LIMITATIONS.—

"(1) TAX LIMITED TO AVERAGE PREMIUM.—

"(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

"(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

"(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the case of any taxpayer who fails to meet the requirements of subsection (e) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

"(2) PRORATION FOR PART YEAR FAILURES.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as—

"(A) the aggregate periods during such taxable year for which such individual failed to meet the requirements of subsection (d), bears to

"(B) the entire taxable year.

"(c) EXCEPTIONS.—

"(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for any taxable year beginning in the same calendar year as such taxable year.

"(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a nonresident alien.

"(3) INDIVIDUALS RESIDING OUTSIDE UNITED STATES.—Any qualified individual (as defined in section 911(d)) (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1), whichever is applicable.

"(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

"(5) RELIGIOUS CONSCIENCE EXEMPTION.—

"(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

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

"(d) ACCEPTABLE COVERAGE REQUIREMENT.—

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

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

"(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the America's Affordable Health Choices Act of 2009).

"(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRANDFATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102 of the America's Affordable Health Choices Act of 2009) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

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

"(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

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

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

"(G) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

"(e) OTHER DEFINITIONS AND SPECIAL RULES.—

"(1) QUALIFYING CHILD.—For purposes of this section, the term 'qualifying child' has the meaning given such term by section 152(c). With respect to any period during which health coverage for a child must be provided by an individual pursuant to a child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

"(2) BASIC PLAN.—For purposes of this section, the term 'basic plan' has the meaning given such term under section 100(c) of the America's Affordable Health Choices Act of 2009.

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

"(4) FAMILY COVERAGE.—For purposes of this section, the term 'family coverage' means any coverage other than self-only coverage.

"(5) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to section 911, and

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

"(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

"(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

"(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

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

(b) INFORMATION REPORTING.—

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

"SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

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

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

"(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

"(C) such other information as the Secretary may require.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

"(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.".

(2) PENALTY FOR FAILURE TO FILE.—

(A) RETURN.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or", and by adding at the end the following new clause:

"(xxiv) section 6050X (relating to returns relating to health insurance coverage), and".

(B) STATEMENT.—Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or", and by inserting after subparagraph (FF) the following new subparagraph:

"(GG) section 6050X (relating to returns relating to health insurance coverage).".

(c) RETURN REQUIREMENT.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.".

(d) CLERICAL AMENDMENTS.—

(1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"PART VIII. HEALTH CARE RELATED TAXES.".

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

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

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

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

(2) RETURNS.—The amendments made by subsection (b) shall apply to calendar years beginning after December 31, 2012.

PART 2—EMPLOYER RESPONSIBILITY

SEC. 411. ELECTION TO SATISFY HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

"(1) IN GENERAL.—Subsection (b) shall apply to any employer with respect to whom an election under paragraph (2) is in effect.

"(2) TIME AND MANNER.—An employer may make an election under this paragraph at such time and in such form and manner as the Secretary may prescribe.

"(3) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414, the election under paragraph (2) shall be made by such person as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

"(4) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

"(A) separate lines of business, and

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

"(5) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

"(b) EXCISE TAX WITH RESPECT TO FAILURE TO MEET HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

"(1) IN GENERAL.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee to whom such election applies, there is hereby imposed on each such failure with respect to each such employee a tax of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

"(2) LIMITATIONS ON AMOUNT OF TAX.—

"(A) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that such failure existed.

"(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

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

"(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

"(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for employment-based health plans, or

"(ii) $500,000.

"(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 2793(g) of the Public Health Service Act with respect to such failure.

"(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term 'health coverage participation requirements' means the requirements of part I of subtitle B of title III of the America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of this section).".

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

"Sec. 4980H. Election with respect to health coverage participation requirements.".

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

SEC. 412. RESPONSIBILITIES OF NONELECTING EMPLOYERS.

(a) IN GENERAL.—Section 3111 of the Internal Revenue Code of 1986 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

"(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

"(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

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

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

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

"(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)) during such calendar year.

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

"(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

"(5) AGGREGATION; PREDECESSORS.—For purposes of this subsection—

"(A) all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer, and

"(B) any reference to any person shall be treated as including a reference to any predecessor of such person.".

(b) DEFINITIONS.—Section 3121 of such Code is amended by adding at the end the following new subsection:

"(aa) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3111(c)—

"(1) Paragraphs (1), (5), and (19) of subsection (b) shall not apply.

"(2) Paragraph (7) of subsection (b) shall apply by treating all services as not covered by the retirement systems referred to in subparagraphs (C) and (F) thereof.

"(3) Subsection (e) shall not apply and the term 'State' shall include the District of Columbia.".

(c) CONFORMING AMENDMENT.—Subsection (d) of section 3111 of such Code, as redesignated by this section, is amended by striking "this section" and inserting "subsections (a) and (b)".

(d) APPLICATION TO RAILROADS.—

(1) IN GENERAL.—Section 3221 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

"(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.

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

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

"(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.".

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

"(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3221(c)—

"(A) Paragraph (1) shall be applied without regard to the third sentence thereof.

"(B) Paragraph (2) shall not apply.".

(3) CONFORMING AMENDMENT.—Subsection (d) of section 3221 of such Code, as redesignated by this section, is amended by striking "subsections (a) and (b), see section 3231(e)(2)" and inserting "this section, see paragraphs (2) and (13)(B) of section 3231(e)".

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

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

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

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

"SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

"(a) IN GENERAL.—For purposes of section 38, in the case of a qualified small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

"(b) APPLICABLE PERCENTAGE.—

"(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

"(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

"(c) LIMITATIONS.—

"(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as—

"(A) the excess of—

"(i) the number of qualified employees employed by the employer during the taxable year, over

"(ii) 10, bears to

"(B) 15.

"(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No credit shall be allowed under subsection (a) with respect to qualified employee health coverage expenses paid or incurred with respect to any employee for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $80,000.

"(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EXPENSES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified employee health coverage expenses' means, with respect to any employer for any taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage.

"(2) QUALIFIED HEALTH COVERAGE.—The term 'qualified health coverage' means acceptable coverage (as defined in section 59B(d)) which—

"(A) is provided pursuant to an election under section 4980H(a), and

"(B) satisfies the requirements referred to in section 4980H(c).

"(e) OTHER DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term 'qualified small employer' means any employer for any taxable year if—

"(A) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

"(B) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

"(2) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation from such employer for services performed in the trade or business of such employer during such taxable year.

"(3) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term 'average annual employee compensation' means, with respect to any employer for any taxable year, the average amount of compensation paid by such employer to qualified employees of such employer during such taxable year.

"(4) COMPENSATION.—The term 'compensation' has the meaning given such term in section 408(p)(6)(A).

"(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

"(f) SPECIAL RULES.—For purposes of this section—

"(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined without regard to this paragraph) with respect to whom the election under 4980H(a) applies, each partner (or, in the case of a trade or business carried on by an individual, such individual) shall be treated as an employee.

"(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

"(3) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance coverage to which subsection (a) applies shall be reduced by the amount of the credit determined under this section.

"(4) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each of the dollar amounts in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.".

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking "plus" at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting ", plus" , and by adding at the end the following new paragraph:

"(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business employee health coverage credit determined under section 45R(a).".

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 45Q the following new item:

"Sec. 45R. Small business employee health coverage credit.".

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

Subtitle C—Disclosures to Carry Out Health Insurance Exchange Subsidies

SEC. 431. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

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

"(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.—

"(A) IN GENERAL.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 208 of the America's Affordable Health Choices Act of 2009, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

"(iv) the number of dependents of the taxpayer,

"(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

"(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009 and providing for the repayment of any such credit which was in excess of such appropriate amount.".

(b) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting ", or any entity described in subsection (l)(21)," after "or (20)" in the matter preceding subparagraph (A),

(2) by inserting "or any entity described in subsection (l)(21)," after "or (o)(1)(A)," in subparagraph (F)(ii), and

(3) by inserting "or any entity described in subsection (l)(21)," after "or (20)," both places it appears in the matter after subparagraph (F).

(c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".

Subtitle D—Other Revenue Provisions

PART 1—GENERAL PROVISIONS

SEC. 441. SURCHARGE ON HIGH INCOME INDIVIDUALS.

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

"Subpart B—Surcharge on High Income Individuals

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

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

"(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to—

"(1) 1 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $350,000 but does not exceed $500,000,

"(2) 1.5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000 but does not exceed $1,000,000, and

"(3) 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

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

"(1) 50 percent of the dollar amount so in effect in the case of a married individual filing a separate return, and

"(2) 80 percent of the dollar amount so in effect in any other case.

"(c) ADJUSTMENTS BASED ON FEDERAL HEALTH REFORM SAVINGS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), in the case of any taxable year beginning after December 31, 2012, subsection (a) shall be applied—

"(A) by substituting '2 percent' for '1 percent', and

"(B) by substituting '3 percent' for '1.5 percent'.

"(2) ADJUSTMENTS BASED ON EXCESS FEDERAL HEALTH REFORM SAVINGS.—

"(A) EXCEPTION IF FEDERAL HEALTH REFORM SAVINGS SIGNIFICANTLY EXCEEDS BASE AMOUNT.—If the excess Federal health reform savings is more than $150,000,000,000 but not more than $175,000,000,000, paragraph (1) shall not apply.

"(B) FURTHER ADJUSTMENT FOR ADDITIONAL FEDERAL HEALTH REFORM SAVINGS.—If the excess Federal health reform savings is more than $175,000,000,000, paragraphs (1) and (2) of subsection (a) (and paragraph (1) of this subsection) shall not apply to any taxable year beginning after December 31, 2012.

"(C) EXCESS FEDERAL HEALTH REFORM SAVINGS.—For purposes of this subsection, the term 'excess Federal health reform savings' means the excess of—

"(i) the Federal health reform savings, over

"(ii) $525,000,000,000.

"(D) FEDERAL HEALTH REFORM SAVINGS.—The term 'Federal health reform savings' means the sum of the amounts described in subparagraphs (A) and (B) of paragraph (3).

"(3) DETERMINATION OF FEDERAL HEALTH REFORM SAVINGS.—Not later than December 1, 2012, the Director of the Office of Management and Budget shall—

"(A) determine, on the basis of the study conducted under paragraph (4), the aggregate reductions in Federal expenditures which have been achieved as a result of the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009 during the period beginning on October 1, 2009, and ending with the latest date with respect to which the Director has sufficient data to make such determination, and

"(B) estimate, on the basis of such study and the determination under subparagraph (A), the aggregate reductions in Federal expenditures which will be achieved as a result of such provisions and amendments during so much of the period beginning with fiscal year 2010 and ending with fiscal year 2019 as is not taken into account under subparagraph (A).

"(4) STUDY OF FEDERAL HEALTH REFORM SAVINGS.—The Director of the Office of Management and Budget shall conduct a study of the reductions in Federal expenditures during fiscal years 2010 through 2019 which are attributable to the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009. The Director shall complete such study not later than December 1, 2012.

"(5) REDUCTIONS IN FEDERAL EXPENDITURES DETERMINED WITHOUT REGARD TO PROGRAM INVESTMENTS.—For purposes of paragraphs (3) and (4), reductions in Federal expenditures shall be determined without regard to section 1121 of the America's Affordable Health Choices Act of 2009 and other program investments under division B thereof.

"(d) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

"(e) INFLATION ADJUSTMENTS.—

"(1) IN GENERAL.—In the case of taxable years beginning after 2011, the dollar amounts in subsection (a) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof.

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

"(f) SPECIAL RULES.—

"(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

"(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amounts in effect under subsection (a) (after the application of subsections (b) and (e)) shall be decreased by the excess of—

"(A) the amounts excluded from the taxpayer's gross income under section 911, over

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

"(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

"(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.".

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

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

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

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

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

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

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

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by adding at the end the following new subsection:

"(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug or is insulin.".

(d) EFFECTIVE DATES.—The amendment made by this section shall apply to expenses incurred after December 31, 2009.

SEC. 443. DELAY IN APPLICATION OF WORLDWIDE ALLOCATION OF INTEREST.

(a) IN GENERAL.—Paragraphs (5)(D) and (6) of section 864(f) of the Internal Revenue Code of 1986 are each amended by striking "December 31, 2010" and inserting "December 31, 2019".

(b) TRANSITION.—Subsection (f) of section 864 of such Code is amended by striking paragraph (7).

PART 2—PREVENTION OF TAX AVOIDANCE

SEC. 451. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) IN GENERAL.—Section 894 of the Internal Revenue Code of 1986 (relating to income affected by treaty) is amended by adding at the end the following new subsection:

"(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

"(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

"(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term 'deductible related-party payment' means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are members of the same foreign controlled group of entities.

"(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'foreign controlled group of entities' means a controlled group of entities the common parent of which is a foreign corporation.

"(B) CONTROLLED GROUP OF ENTITIES.—The term 'controlled group of entities' means a controlled group of corporations as defined in section 1563(a)(1), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

"(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

"(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term 'foreign parent corporation' means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

"(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

"(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

"(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 452. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

"(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

"(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

"(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

"(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

"(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction

is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

"(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

"(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

"(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

"(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

"(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

"(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

"(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

"(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

"(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.".

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

SEC. 453. PENALTIES FOR UNDERPAYMENTS.

(a) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

(1) IN GENERAL.—Subsection (b) of section 6662 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (5) the following new paragraph:

"(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.".

(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

"(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

"(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

"(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a transaction described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

"(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.".

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(A) by striking "section 6662(h)" and inserting "subsections (h) or (i) of section 6662", and

(B) by striking "GROSS VALUATION MISSTATEMENT PENALTY" in the heading and inserting "CERTAIN INCREASED UNDERPAYMENT PENALTIES".

(b) REASONABLE CAUSE EXCEPTION NOT APPLICABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS, TAX SHELTERS, AND CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subsection (c) of section 6664 of such Code is amended—

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

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

(3) by inserting after paragraph (1) the following new paragraph:

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

"(A) to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6), and

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

(c) APPLICATION OF PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.".

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

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

"(D) SPECIAL REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

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

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

"(II) the amount of the understatement under subparagraph (A) shall be reduced by that portion of the understatement which is attributable to any item with respect to which the taxpayer has a reasonable belief that the tax treatment of such item by the taxpayer is more likely than not the proper tax treatment of such item.

"(ii) SPECIFIED PERSON.—For purposes of this subparagraph, the term 'specified person' means—

"(I) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

"(II) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of subclause (II).".

(2) CONFORMING AMENDMENT.—Subparagraph (C) of section 6662(d)(2) of such Code is amended by striking "Subparagraph (B)" and inserting "Subparagraphs (B) and (D)(i)(II)".

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

PART 3—PARITY IN HEALTH BENEFITS

SEC. 461. CERTAIN HEALTH RELATED BENEFITS APPLICABLE TO SPOUSES AND DEPENDENTS EXTENDED TO ELIGIBLE BENEFICIARIES.

(a) APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.—

(1) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986, as amended by section 442, (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

"(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

"(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

"(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'eligible beneficiary' means any individual who is eligible to receive benefits or coverage under an accident or health plan.".

(2) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of such Code (relating to amounts expended for medical care) is amended—

(A) by striking "and his dependents" and inserting "his dependents", and

(B) by inserting before the period the following: "and any eligible beneficiary (within the meaning of section 106(f)) with respect to the taxpayer".

(3) PAYROLL TAXES.—

(A) Section 3121(a)(2) of such Code is amended—

(i) by striking "or any of his dependents" in the matter preceding subparagraph (A) and inserting ", any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee",

(ii) by striking "or any of his dependents," in subparagraph (A) and inserting ", any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,", and

(iii) by striking "and their dependents" both places it appears and inserting "and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))".

(B) Section 3231(e)(1) of such Code is amended—

(i) by striking "or any of his dependents" and inserting ", any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,", and

(ii) by striking "and their dependents" both places it appears and inserting "and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))".

(C) Section 3306(b)(2) of such Code is amended—

(i) by striking "or any of his dependents" in the matter preceding subparagraph (A) and inserting ", any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,",

(ii) by striking "or any of his dependents" in subparagraph (A) and inserting ", any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee", and

(iii) by striking "and their dependents" both places it appears and inserting "and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))".

(D) Section 3401(a) of such Code is amended by striking "or" at the end of paragraph (22), by striking the period at the end of paragraph (23) and inserting "; or", and by inserting after paragraph (23) the following new paragraph:

"(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(g).".

(b) EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

"(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

"(A) the taxpayer,

"(B) the taxpayer's spouse,

"(C) the taxpayer's dependents, and

"(D) any individual who—

"(i) satisfies the age requirements of section 152(c)(3)(A),

"(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

"(iii) meets the requirements of section 152(d)(1)(C), and

"(E) one individual who—

"(i) does not satisfy the age requirements of section 152(c)(3)(A),

"(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

"(iii) meets the requirements of section 152(d)(1)(D), and

"(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).".

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(l)(2) of such Code is amended by inserting ", any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to" after "spouse".

(c) EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.—Section 501(c)(9) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new sentence: "For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term 'dependents' shall include any individual who is an eligible beneficiary (within the meaning of section 106(f)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.".

(d) FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's flexible spending arrangement, notwithstanding the fact that such expenses are attributable to any individual who is not the employee's spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(f) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's health reimbursement arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(f) of such Code) under the health reimbursement arrangement with respect to the employee.

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

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 1001. TABLE OF CONTENTS OF DIVISION.

The table of contents for this division is as follows:

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

Sec. 1001. Table of contents of division.

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

PART 2—OTHER MEDICARE PART A PROVISIONS

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

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

Sec. 1121. Sustainable growth rate reform.
Sec. 1122. Misvalued codes under the physician fee schedule.
Sec. 1123. Payments for efficient areas.
Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).
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PART 2—MARKET BASKET UPDATES

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

PART 3—OTHER PROVISIONS

Sec. 1141. Rental and purchase of power-driven wheelchairs.

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

Subtitle C—Provisions Related to Medicare Parts A and B

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

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

Sec. 1161. Phase-in of payment based on fee-for-service costs.
Sec. 1162. Quality bonus payments.
Sec. 1163. Extension of Secretarial coding intensity adjustment authority.
Sec. 1164. Simplification of annual beneficiary election periods.
Sec. 1165. Extension of reasonable cost contracts.
Sec. 1166. Limitation of waiver authority for employer group plans.
Sec. 1167. Improving risk adjustment for payments.
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PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

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Sec. 1631. Enhanced CMS program protection authority.
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Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals.
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Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
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Sec. 1645. Conforming civil monetary penalties to False Claims Act amendments.

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

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

[FOR ITEMS RELATING TO TITLE VII OF DIVISION B, SEE COPY OF BILL AS INTRODUCED ON JULY 14, 2009]

TITLE VIII—REVENUE-RELATED PROVISIONS

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

TITLE IX—MISCELLANEOUS PROVISIONS

Sec. 1901. Repeal of trigger provision.
Sec. 1902. Repeal of comparative cost adjustment (CCA) program.
Sec. 1903. Extension of gainsharing demonstration.
Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children.
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TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.

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

(1) in subclause (III), by striking "and" at the end;

(2) by redesignating subclause (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

"(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

"(V) for fiscal year 2010, the rate computed for the previous fiscal year; and".

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2010.

SEC. 1102. INPATIENT REHABILITATION FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by striking "and 2009" and inserting "through 2010".

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (iii)—

(A) by striking "(iii) For purposes of this subparagraph," and inserting "(iii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (II),"; and

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

"(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published before the promulgation of such increase for the year or period involved). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in subclause (I) minus the percentage change under this subclause.";

(2) in the first sentence of clause (viii)(I), by inserting "(but not below zero)" after "shall be reduced"; and

(3) in the first sentence of clause (ix)(I)—

(A) by inserting "(determined without regard to clause (iii)(II)" after "clause (i)" the second time it appears; and

(B) by inserting "(but not below zero)" after "reduced".

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5))(B) is amended by inserting "subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)" after "as calculated by the Secretary".

(c) LONG TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

"(3) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2010 or any subsequent rate year for a hospital, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).".

(d) INPATIENT REHABILITATION FACILITIES.—The second sentence of section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by inserting "(subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II))" after "appropriate percentage increase".

(e) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

"(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

"(2) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2011 or any subsequent rate year for a psychiatric hospital or unit described in such paragraph, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital or unit, respectively, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).".

(f) HOSPICE CARE.—Subclause (VII) of section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended by inserting after "the market basket percentage increase" the following: "(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))".

(g) EFFECTIVE DATE.—The amendments made by subsections (a), (b), (d), and (f) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG–53 and under the RUG–44 classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year 2010 by the appropriate recalibration factor as proposed in the proposed rule for Medicare skilled nursing facilities issued by such Secretary on May 12, 2009 (74 Federal Register 22214 et seq.).

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.—

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

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

(B) EFFECTIVE DATE.—The changes in payment described in subparagraph (A) shall apply for days on or after January 1, 2010, and until the Secretary implements an alternative case mix classification system for payment of skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(C) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.

(2) CHANGES UNDER A FUTURE SNF CASE MIX CLASSIFICATION SYSTEM.—

(A) ANALYSIS.—

(i) IN GENERAL.—The Secretary of Health and Human Services shall analyze payments for non-therapy ancillary services under a future skilled nursing facility classification system to ensure the accuracy of payment for non-therapy ancillary services. Such analysis shall consider use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay, diagnoses, broad RUG category, and a proxy for length of stay.

(ii) APPLICATION.—Such analysis shall be conducted in a manner such that the future skilled nursing facility classification system is implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(B) CONSULTATION.—In conducting the analysis under subparagraph (A), the Secretary shall consult with interested parties, including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of nontherapy ancillary costs.

(C) RULEMAKING.—The Secretary shall include the result of the analysis under subparagraph (A) in the fiscal year 2011 rulemaking cycle for purposes of implementation beginning for such fiscal year.

(D) IMPLEMENTATION.—Subject to subparagraph (E) and consistent with subparagraph (A)(ii), the Secretary shall implement changes to payments for non-therapy ancillary services (which shall include a separate rate component for non-therapy ancillary services and may include use of a model that predicts payment amounts applicable for non-therapy ancillary services) under such future skilled nursing facility services classification system as the Secretary determines appropriate based on the analysis conducted pursuant to subparagraph (A).

(E) BUDGET NEUTRALITY.—The Secretary shall implement changes described in subparagraph (D) in a manner such that the estimated expenditures under such future skilled nursing facility services classification system for a fiscal year beginning with fiscal year 2011 with such changes would be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under such future skilled nursing facility services classification system for such year without such changes.

(c) OUTLIER POLICY FOR NTA AND THERAPY.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended by adding at the end the following new paragraph:

"(13) OUTLIERS FOR NTA AND THERAPY.—

"(A) IN GENERAL.—With respect to outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010, the Secretary—

"(i) shall provide for an addition or adjustment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers; and

"(ii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to therapy services in the case of such outliers.

"(B) OUTLIERS BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

"(C) BUDGET NEUTRALITY.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year may not exceed 2 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.".

(d) CONFORMING AMENDMENTS.—Section 1888(e)(8) of such Act (42 U.S.C. 1395yy(e)(8)) is amended—

(1) in subparagraph (A)—

(A) by striking "and" before "adjustments"; and

(B) by inserting ", and adjustment under section 1111(b) of the America's Affordable Health Choices Act of 2009" before the semicolon at the end;

(2) in subparagraph (B), by striking "and";

(3) in subparagraph (C), by striking the period and inserting "; and"; and

(4) by adding at the end the following new subparagraph:

"(D) the establishment of outliers under paragraph (13).".

SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH REPORT.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain.

(2) COORDINATION WITH MEDICAID DSH REPORT.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1704(a).

(b) PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.—

(1) IN GENERAL.—If there is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under paragraph (2)(A)), then the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) In lieu of the amount of Medicare DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Social Security Act, the amount of Medicare DSH payment shall be an amount based on the recommendations of the report under subsection (a)(1)(A) and shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size.

(B) Subject to paragraph (3), make an additional payment to a hospital by an amount that is estimated based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

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

(A) IN GENERAL.—There is a "significant decrease in the national rate of uninsurance as a result of this Act" if there is a decrease in the national

rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(B) NATIONAL RATE OF UNINSURANCE DEFINED.—The term "national rate of uninsurance" means, for a year, such rate for the under-65 population for the year as determined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

(3) UNCOMPENSATED CARE INCREASE.—

(A) COMPUTATION OF DSH SAVINGS.—For each fiscal year (beginning with fiscal year 2017), the Secretary shall estimate the aggregate reduction in the amount of Medicare DSH payment that would be expected to result from the adjustment under paragraph (1)(A).

(B) STRUCTURE OF PAYMENT INCREASE.—The Secretary shall compute the additional payment to a hospital as described in paragraph (1)(B) for a fiscal year in accordance with a formula established by the Secretary that provides that—

(i) the estimated aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and

(ii) hospitals with higher levels of uncompensated care receive a greater increase.

(c) MEDICARE DSH.—In this section, the term "Medicare DSH" means adjustments in payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services furnished by disproportionate share hospitals.

SEC. 1113. EXTENSION OF HOSPICE REGULATION MORATORIUM.

Section 4301(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) by striking "October 1, 2009" and inserting "October 1, 2010"; and

(2) by striking "for fiscal year 2009" and inserting "for fiscal years 2009 and 2010".

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS' SERVICES

SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.

(a) TRANSITIONAL UPDATE FOR 2010.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

"(10) UPDATE FOR 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.".

(b) REBASING SGR USING 2009; LIMITATION ON CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4) of such Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in subparagraph (B), by striking "subparagraph (D)" and inserting "subparagraphs (D) and (G)"; and

(2) by adding at the end the following new subparagraph:

"(G) REBASING USING 2009 FOR FUTURE UPDATE ADJUSTMENTS.—In determining the update adjustment factor under subparagraph (B) for 2011 and subsequent years—

"(i) the allowed expenditures for 2009 shall be equal to the amount of the actual expenditures for physicians' services during 2009; and

"(ii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated as a reference to 'January 1, 2009 (or, if later, the first day of the fifth year before the year involved)'.".

(c) LIMITATION ON PHYSICIANS' SERVICES INCLUDED IN TARGET GROWTH RATE COMPUTATION TO SERVICES COVERED UNDER PHYSICIAN FEE SCHEDULE.—Effective for services furnished on or after January 1, 2009, section 1848(f)(4)(A) of such Act is amended by striking "(such as clinical" and all that follows through "in a physician's office" and inserting "for which payment under this part is made under the fee schedule under this section, for services for practitioners described in section 1842(b)(18)(C) on a basis related to such fee schedule, or for services described in section 1861(p) (other than such services when furnished in the facility of a provider of services)".

(d) ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR CATEGORIES OF SERVICES.—

(1) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

"(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2009, each of the following categories of physicians' services (as defined in paragraph (3)) shall be treated as a separate 'service category':

"(A) Evaluation and management services that are procedure codes (for services covered under this title) for—

"(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under subsection (c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

"(ii) preventive services (as defined in section 1861(iii)) for which payment is made under this section.

"(B) All other services not described in subparagraph (A).

Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service.".

(2) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subparagraph (A)—

(i) by designating the sentence beginning "The conversion factor" as clause (i) with the heading "APPLICATION OF SINGLE CONVERSION FACTOR.—" and with appropriate indentation;

(ii) by striking "The conversion factor" and inserting "Subject to clause (ii), the conversion factor"; and

(iii) by adding at the end the following new clause:

"(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2011.—

"(I) IN GENERAL.—In applying clause (i) for years beginning with 2011, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

"(II) INITIAL CONVERSION FACTORS.—Such factors for 2011 shall be based upon the single conversion factor for the previous year multiplied by the update established under paragraph (11) for such category for 2011.

"(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (11) for the year involved."; and

(B) in subparagraph (D), by striking "other physicians' services" and inserting "for physicians' services described in the service category described in subsection (j)(5)(B)".

(3) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by subsection (a), is amended—

(A) in paragraph (4)(C)(iii), by striking "The allowed" and inserting "Subject to paragraph (11)(B), the allowed"; and

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

"(11) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2011.—

"(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2011, the following rules apply:

"(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

"(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

"(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and ac-

tual expenditures for the service category, as determined under subparagraph (B).

"(II) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

"(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2010, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

"(i) FOR 2010.—For 2010:

"(I) TOTAL 2009 ACTUAL EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION FOR EACH SERVICE CATEGORY.—Compute total actual expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2009 for each service category.

"(II) INCREASE BY GROWTH RATE TO OBTAIN 2010 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2010 by increasing the allowed expenditures for the service category for 2009 computed under subclause (I) by the target growth rate for such service category under subsection (f) for 2010.

"(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.".

(4) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(A) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

"(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2010.—The target growth rate for a year beginning with 2010 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the target growth rate except that the factor described in paragraph (2)(C) for—

"(A) the service category described in subsection (j)(5)(A) shall be increased by 0.02; and

"(B) the service category described in subsection (j)(5)(B) shall be increased by 0.01.".

(B) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(i) in subsection (d)—

(I) in paragraph (1)(E)(ii), by inserting "or target" after "sustainable"; and

(II) in paragraph (4)(B)(ii)(II), by inserting "or target" after "sustainable"; and

(ii) in the heading of subsection (f), by inserting "AND TARGET GROWTH RATE" after "SUSTAINABLE GROWTH RATE";

(iii) in subsection (f)(1)—

(I) by striking "and" at the end of subparagraph (A);

(II) in subparagraph (B), by inserting "before 2010" after "each succeeding year" and by striking the period at the end and inserting "; and"; and

(III) by adding at the end the following new subparagraph:

"(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years."; and

(iv) in subsection (f)(2), in the matter before subparagraph (A), by inserting after "beginning with 2000" the following: "and ending with 2009".

(e) APPLICATION TO ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.—In applying the target growth rate under subsections (d) and (f) of section 1848 of the Social Security Act to services furnished by a practitioner to beneficiaries who are attributable to an accountable care organization under the pilot program provided under section 1866D of such Act, the Secretary of Health and Human Services shall develop, not later than January 1, 2012, for application beginning with 2012, a method that—

(1) allows each such organization to have its own expenditure targets and updates for such practitioners, with respect to beneficiaries who are attributable

to that organization, that are consistent with the methodologies described in such subsection (f); and

(2) provides that the target growth rate applicable to other physicians shall not apply to such physicians to the extent that the physicians' services are furnished through the accountable care organization.

In applying paragraph (1), the Secretary of Health and Human Services may apply the difference in the update under such paragraph on a claim-by-claim or lump sum basis and such a payment shall be taken into account under the pilot program.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

"(K) POTENTIALLY MISVALUED CODES.—

"(i) IN GENERAL.—The Secretary shall—

"(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

"(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

"(iii) REVIEW AND ADJUSTMENTS.—

"(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described clause (i)(II).

"(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

"(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

"(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

"(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

"(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) VALIDATING RELATIVE VALUE UNITS.—

"(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

"(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

"(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii)

"(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

"(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).".

(b) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $20,000,000 for fiscal year 2010 and each subsequent fiscal year. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(3) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 1395ee(a)) is repealed.

SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.

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

"(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

"(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

"(2) IDENTIFICATION OF EFFICIENT AREAS.—

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

"(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

"(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

"(i) the identification of a county or other area under subparagraph (A); or

"(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

"(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the pro-

posed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.".

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

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

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

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

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

(2) by adding at the end the following new subparagraph:

"(I) INFORMAL APPEALS PROCESS.—Notwithstanding subparagraph (E), by not later than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to appeal the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.".

(c) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of such Act is amended by adding at the end the following new paragraph:

"(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

"(A) The development of measures, the reporting of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) clinical quality of care furnished to an individual.

"(B) The collection of health data to identify deficiencies in the quality and coordination of care for individuals eligible for benefits under this part.

"(C) Such other activities as specified by the Secretary.".

(d) EXTENSION OF INCENTIVE PAYMENTS.—Section 1848(m)(1) of such Act (42 U.S.C. 1395w–4(m)(1)) is amended—

(1) in subparagraph (A), by striking "2010" and inserting "2012"; and

(2) in subparagraph (B)(ii), by striking "2009 and 2010" and inserting "for each of the years 2009 through 2012".

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C.1395w–4(e)) is amended by adding at the end the following new paragraph:

"(6) TRANSITION TO USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

"(A) IN GENERAL.—

"(i) REVISION.—Subject to clause (ii) and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2011, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the Metropolitan Statistical Area (MSA) iterative Geographic Adjustment Factor methodology as follows:

"(I) The Secretary shall configure the physician fee schedule areas using the Core-Based Statistical Areas-Metropolitan Statistical Areas (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget, as the basis for the fee schedule areas. The Secretary shall employ an iterative process to transition fee schedule areas. First, the Secretary shall list all MSAs within the State by Geographic Adjustment Factor described in paragraph (2) (in this paragraph referred to as a 'GAF') in descending order. In the first iteration, the Secretary shall compare the GAF of the highest cost MSA in the State to the weighted-average GAF of the group of remaining MSAs in the State. If the ratio of the GAF of the highest cost MSA to the weighted-average GAF of the rest of State is 1.05 or greater then the highest cost MSA becomes a separate fee schedule area.

"(II) In the next iteration, the Secretary shall compare the MSA of the second-highest GAF to the weighted-average GAF of the group of remaining MSAs. If the ratio of the second-highest MSA's

GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, the second-highest MSA becomes a separate fee schedule area. The iterative process continues until the ratio of the GAF of the highest-cost remaining MSA to the weighted-average of the remaining lower-cost MSAs is less than 1.05, and the remaining group of lower cost MSAs form a single fee schedule area, If two MSAs have identical GAFs, they shall be combined in the iterative comparison.

"(ii) TRANSITION.—For services furnished on or after January 1, 2011, and before January 1, 2016, in the State of California, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply through application of this paragraph, the Secretary shall increase any such index to the county-based fee schedule area value on December 31, 2009, if such index would otherwise be less than the value on January 1, 2010.

"(B) SUBSEQUENT REVISIONS.—

"(i) PERIODIC REVIEW AND ADJUSTMENTS IN FEE SCHEDULE AREAS.—Subsequent to the process outlined in paragraph (1)(C), not less often than every three years, the Secretary shall review and update the California Rest-of-State fee schedule area using MSAs as defined by the Director of the Office of Management and Budget and the iterative methodology described in subparagraph (A)(i).

"(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of the adjustment factors required under paragraph (1)(C) for California for 2012 and subsequent periods. Upon request, the Secretary shall make available to the public any county-level or MSA derived data used to calculate the geographic practice cost index.

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

(b) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w(j)(2)) is amended by striking "The term" and inserting "Except as provided in subsection (e)(6)(C), the term".

PART 2—MARKET BASKET UPDATES

SEC. 1131. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) OUTPATIENT HOSPITALS.—

(1) IN GENERAL.—The first sentence of section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended—

(A) by inserting "(which is subject to the productivity adjustment described in subclause (II) of such section)" after "1886(b)(3)(B)(iii)"; and

(B) by inserting "(but not below 0)" after "reduced".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to increase factors for services furnished in years beginning with 2010.

(b) AMBULANCE SERVICES.—Section 1834(l)(3)(B) of such Act (42 U.S.C. 1395m(l)(3)(B))) is amended by inserting before the period at the end the following: "and, in the case of years beginning with 2010, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)".

(c) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of such Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

"(v) In implementing the system described in clause (i), for services furnished during 2010 or any subsequent year, to the extent that an annual percentage change factor applies, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).".

(d) LABORATORY SERVICES.—Section 1833(h)(2)(A) of such Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i), by striking "for each of the years 2009 through 2013" and inserting "for 2009"; and

(2) clause (ii)—

(A) by striking "and" at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting "; and"; and

(C) by adding at the end the following new subclause:

"(V) the annual adjustment in the fee schedules determined under clause (i) for years beginning with 2010 shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).".

(e) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of such Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K), by inserting before the semicolon at the end the following: ", subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)";

(2) in subparagraph (L)(i), by inserting after "June 2013," the following: "subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II),";

(3) in subparagraph (L)(ii), by inserting after "June 2013" the following: ", subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)"; and

(4) in subparagraph (M), by inserting before the period at the end the following: ", subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)".

PART 3—OTHER PROVISIONS

SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) in the heading, by inserting "CERTAIN COMPLEX REHABILITATIVE" after "OPTION FOR"; and

(2) by striking "power-driven wheelchair" and inserting "complex rehabilitative power-driven wheelchair recognized by the Secretary as classified within group 3 or higher".

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

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking, the first place it appears, "January 1, 2010" and inserting "January 1, 2012".

SEC. 1143. HOME INFUSION THERAPY REPORT TO CONGRESS.

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

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran's health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of the scope of services provided by home infusion therapy providers to their patients in such programs.

(2) The benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital and nursing home stays as a result of Medicare coverage of home infusion therapy.

(3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program.

(4) Recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy and their applicability to the Medicare program.

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

(a) COST REPORTING.—

(1) IN GENERAL.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

"(8) The Secretary shall require, as a condition of the agreement described in section 1832(a)(2)(F)(i), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.".

(2) DEVELOPMENT OF COST REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop a cost report form for use under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

(3) AUDIT REQUIREMENT.—The Secretary shall provide for periodic auditing of cost reports submitted under section 1833(i)(8) of the Social Security Act, as added by paragraph (1).

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

(b) ADDITIONAL DATA ON QUALITY.—

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

(A) in subparagraph (B), by inserting "subject to subparagraph (C)," after "may otherwise provide,"; and

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

"(C) Under subparagraph (B) the Secretary shall require the reporting of such additional data relating to quality of services furnished in an ambulatory surgical facility, including data on health care associated infections, as the Secretary may specify.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall to reporting for years beginning with 2012.

SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

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

"(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

"(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

"(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.".

SEC. 1146. MEDICARE IMPROVEMENT FUND.

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

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

SEC. 1147. PAYMENT FOR IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking "subparagraph (A)" and inserting "this paragraph"; and

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

"(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)), the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."; and

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

(b) ADJUSTMENT IN TECHNICAL COMPONENT "DISCOUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

"(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure

payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.".

(c) EFFECTIVE DATE.—Except as otherwise provided, this section, and the amendments made by this section, shall apply to services furnished on or after January 1, 2011.

SEC. 1148. DURABLE MEDICAL EQUIPMENT PROGRAM IMPROVEMENTS.

(a) WAIVER OF SURETY BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended by adding at the end the following: "The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy (i) that has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued (which may include renewal of) a provider number (as described in the first sentence of this paragraph) for at least 5 years, and (ii) for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed.".

(b) ENSURING SUPPLY OF OXYGEN EQUIPMENT .—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in clause (ii), by striking "After the" and inserting "Except as provided in clause (iii), after the"; and

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

"(iii) CONTINUATION OF SUPPLY.—In the case of a supplier furnishing such equipment to an individual under this subsection as of the 27th month of the 36 months described in clause (i), the supplier furnishing such equipment as of such month shall continue to furnish such equipment to such individual (either directly or though arrangements with other suppliers of such equipment) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier has accepted responsibility for continuing to furnish such equipment during the remainder of such period.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as of the date of the enactment of this Act and shall apply to the furnishing of equipment to individuals for whom the 27th month of a continuous period of use of oxygen equipment described in section 1834(a)(5)(F) of the Social Security Act occurs on or after July 1, 2010.

(c) TREATMENT OF CURRENT ACCREDITATION APPLICATIONS.—Section 1834(a)(20)(F) of such Act (42 U.S.C. 1395m(a)(20)(F)) is amended—

(1) in clause (i)—

(A) by striking "clause (ii)" and inserting "clauses (ii) and (iii)"; and

(B) by striking "and" at the end;

(2) by striking the period at the end of clause (ii)(II) and by inserting "; and";

(3) by inserting after clause (ii) the following new clause:

"(iii) the requirement for accreditation described in clause (i) shall not apply for purposes of supplying diabetic testing supplies, canes, and crutches in the case of a pharmacy that is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies."; and

(4) by adding after and below clause (iii) the following:

"Any supplier that has submitted an application for accreditation before August 1, 2009, shall be deemed as meeting applicable standards and accreditation requirement under this subparagraph until such time as the independent accreditation organization takes action on the supplier's application.".

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

"(iv) EXCEPTION FOR BANKRUPTCY.—If a supplier who furnishes oxygen and oxygen equipment to an individual is declared bankrupt and its assets are liquidated and at the time of such declaration and liquidation more than 24 months of rental payments have been made, such individual may begin a new 36-month rental period under this subparagraph with another supplier of oxygen.".

SEC. 1149. MEDPAC STUDY AND REPORT ON BONE MASS MEASUREMENT.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptriometry, and vertebral fracture assessment. The study shall focus on the following:

(1) An assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs.

(2) The impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically.

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

(4) In conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries.

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

Subtitle C—Provisions Related to Medicare Parts A and B

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS.

(a) HOSPITALS.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

"(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EXCESS READMISSIONS.—

"(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

"(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

"(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

"(2) BASE OPERATING DRG PAYMENT AMOUNT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year, the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

"(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

"(3) ADJUSTMENT FACTOR.—

"(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in subparagraph (C).

"(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

"(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

"(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

"(i) fiscal year 2012 is 0.99;

"(ii) fiscal year 2013 is 0.98;

"(iii) fiscal year 2014 is 0.97; or

"(iv) a subsequent fiscal year is 0.95.

"(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

"(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for a fiscal year, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

"(i) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

"(ii) the number of admissions for such condition for such hospital for such fiscal year; and

"(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for the applicable period for such fiscal year minus 1.

"(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for a fiscal year, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such fiscal year.

"(C) EXCESS READMISSION RATIO.—

"(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

"(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

"(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

"(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

"(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under subparagraph (C) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 50th percentile.

"(5) DEFINITIONS.—For purposes of this subsection:

"(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

"(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of

readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

"(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3).

"(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

"(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

"(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) the determination of base operating DRG payment amounts;

"(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5);

"(C) the measures of readmissions as described in paragraph (5)(A)(ii); and

"(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in payment under paragraph (8)(B)(ii), the aggregate cap under paragraph (8)(C)(i), the hospital-specific limit under paragraph (8)(C)(ii), and the form of payment made by the Secretary under paragraph (8)(D).

"(7) MONITORING INAPPROPRIATE CHANGES IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine if such hospitals have taken steps to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction.

"(8) ASSISTANCE TO CERTAIN HOSPITALS.—

"(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps described in subparagraph (E) to address factors that may impact readmissions of individuals who are discharged from such a hospital, for fiscal years beginning on or after October 1, 2011, the Secretary shall make a payment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C).

"(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

"(i) received (or, in the case of an 1814(b)(3) hospital, otherwise would have been eligible to receive) $10,000,000 or more in disproportionate share payments using the latest available data as estimated by the Secretary; and

"(ii) provides assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E).

"(C) CAPS.—

"(i) AGGREGATE CAP.—The aggregate amount of the payment adjustment under this paragraph for a fiscal year shall not exceed 5 percent of the estimated difference in the spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

"(ii) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed the estimated difference in spending that would occur for such fiscal year for such hospital with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

"(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise.

"(E) USE OF ADDITIONAL PAYMENT.—Funding under this paragraph shall be used by targeted hospitals for transitional care activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, such as one or more of the following:

"(i) Providing care coordination services to assist in transitions from the targeted hospital to other settings.

"(ii) Hiring translators and interpreters.

"(iii) Increasing services offered by discharge planners.

"(iv) Ensuring that individuals receive a summary of care and medication orders upon discharge.

"(v) Developing a quality improvement plan to assess and remedy preventable readmission rates.

"(vi) Assigning discharged individuals to a medical home.

"(vii) Doing other activities as determined appropriate by the Secretary.

"(F) GAO REPORT ON USE OF FUNDS.—Not later than 3 years after the date on which funds are first made available under this paragraph, the Comptroller General of the United States shall submit to Congress a report on the use of such funds.

"(G) DISPROPORTIONATE SHARE HOSPITAL PAYMENT.—In this paragraph, the term 'disproportionate share hospital payment' means an additional payment amount under subsection (d)(5)(F).".

(b) APPLICATION TO CRITICAL ACCESS HOSPITALS.—Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended—

(1) in paragraph (5)—

(A) by striking "and" at the end of subparagraph (C);

(B) by striking the period at the end of subparagraph (D) and inserting "; and";

(C) by inserting at the end the following new subparagraph:

"(E) the methodology for determining the adjustment factor under paragraph (5), including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmissions."; and

(D) by redesignating such paragraph as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) The adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection) in a manner similar to the manner in which such section applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2).".

(c) POST ACUTE CARE PROVIDERS.—

(1) INTERIM POLICY.—

(A) IN GENERAL.—With respect to a readmission to an applicable hospital or a critical access hospital (as described in section 1814(l) of the Social Security Act) from a post acute care provider (as defined in paragraph (3)) and such a readmission is not governed by section 412.531 of title 42, Code of Federal Regulations, if the claim submitted by such a post-acute care provider under title XVIII of the Social Security Act indicates that the individual was readmitted to a hospital from such a post-acute care provider or admitted from home and under the care of a home health agency within 30 days of an initial discharge from an applicable hospital or critical access hospital, the payment under such title on such claim shall be the applicable percent specified in subparagraph (B) of the payment that would otherwise be made under the respective payment system under such title for such post-acute care provider if this subsection did not apply.

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

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

(ii) for fiscal or rate year 2013 is 0.993; and

(iii) for fiscal or rate year 2014 is 0.99.

(C) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished (as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal year or rate year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

(2) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall develop appropriate measures of readmission rates for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act but may adopt and apply such measures under this paragraph without such an endorsement. The Secretary shall expand such measures in a manner similar to the manner in which applicable conditions are expanded under paragraph (5)(B) of section 1886(p) of the Social Security Act, as added by subsection (a).

(B) IMPLEMENTATION.—The Secretary shall apply, on or after October 1, 2014, with respect to post acute care providers, policies similar to the policies applied with respect to applicable hospitals and critical access hospitals under the amendments made by subsection (a). The provisions of paragraph (1) shall apply with respect to any period on or after October 1, 2014, and before such application date described in the previous sentence in the same manner as such provisions apply with respect to fiscal or rate year 2014.

(C) MONITORING AND PENALTIES.—The provisions of paragraph (7) of such section 1886(p) shall apply to providers under this paragraph in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term "post acute care provider" means—

(i) a skilled nursing facility (as defined in section 1819(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (described in section 1886(h)(1)(A) of such Act);

(iii) a home health agency (as defined in section 1861(o) of such Act); and

(iv) a long term care hospital (as defined in section 1861(ccc) of such Act).

(B) OTHER TERMS .—The terms "applicable condition", "applicable hospital", and "readmission" have the meanings given such terms in section 1886(p)(5) of the Social Security Act, as added by subsection (a)(1).

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider approaches such as—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act (in a budget neutral manner) for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or critical access hospital;

(B) developing measures of rates of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physicians.

(3) REPORT.—The Secretary shall issue a public report on such study not later than the date that is one year after the date of the enactment of this Act.

(e) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each fiscal year beginning with 2010. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

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

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a detailed plan to reform payment for post acute care (PAC) services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the "Medicare program)". The goals of such payment reform are to—

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

(B) improve outcomes for individuals such as reducing the need for readmission to hospitals from providers of such services.

(2) BUNDLING POST ACUTE SERVICES.—The plan described in paragraph (1) shall include detailed specifications for a bundled payment for post acute services (in this section referred to as the "post acute care bundle"), and may include other approaches determined appropriate by the Secretary.

(3) POST ACUTE SERVICES.—For purposes of this section, the term "post acute services" means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, hospital based outpatient rehabilitation facilities and home health agencies to an individual after discharge of such individual from a hospital, and such other services determined appropriate by the Secretary.

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

(1) The nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and the period covered by the bundle.

(2) Whether the payment should be consolidated with the payment under the inpatient prospective system under section 1886 of the Social Security Act (in this section referred to as MS–DRGs) or a separate payment should be established for such bundle, and if a separate payment is established, whether it should be made only upon use of post acute care services or for every discharge.

(3) Whether the bundle should be applied across all categories of providers of inpatient services (including critical access hospitals) and post acute care services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS–DRGs.

(4) The extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to be achieved with a bundle payment, whether such rates should be established on a national basis or for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences in wages or other appropriate adjustments, and how to update such rates.

(5) The nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed as determined by an appropriate assessment instrument, are offered choice of provider, and the extent to which transitional care services would improve quality of care for individuals and the functioning of a bundled post-acute system.

(6) The nature of relationships that may be required between hospitals and providers of post acute care services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws.

(7) Quality measures that would be appropriate for reporting by hospitals and post acute providers (such as measures that assess changes in functional status and quality measures appropriate for each type of post acute services provider including how the reporting of such quality measures could be coordinated with other reporting of such quality measures by such providers otherwise required).

(8) How cost-sharing for a post acute care bundle should be treated relative to current rules for cost-sharing for inpatient hospital, home health, skilled nursing facility, and other services.

(9) How other programmatic issues should be treated in a post acute care bundle, including rules specific to various types of post-acute providers such as the post-acute transfer policy, three-day hospital stay to qualify for services furnished by skilled nursing facilities, and the coordination of payments and care under the Medicare program and the Medicaid program.

(10) Such other issues as the Secretary deems appropriate.

(c) CONSULTATIONS AND ANALYSIS.—

(1) CONSULTATION WITH STAKEHOLDERS.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies and demonstrations that the Secretary determines appropriate.

(2) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians;

(C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop such plan required in this section; and

(D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Deficit Reduction Act of 2005.

(d) ADMINISTRATION.—

(1) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $15,000,000 for each of the fiscal years 2010 through 2012. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) EXPEDITED DATA COLLECTION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(e) PUBLIC REPORTS.—

(1) INTERIM REPORTS.—The Secretary shall issue interim public reports on a periodic basis on the plan described in subsection (a)(1), the issues described in subsection (b), and impact analyses as the Secretary determines appropriate.

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

(f) CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES.—

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

"CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES

"SEC. 1866D. (a) CONVERSION AND EXPANSION.—

"(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient and high quality delivery of care—

"(A) convert the acute care episode demonstration program conducted under section 1866C to a pilot program; and

"(B) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.

"(2) BUNDLED PAYMENT STRUCTURES.—

"(A) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

"(i) hospitals and physicians;

"(ii) hospitals and post-acute care providers;

"(iii) hospitals, physicians, and post-acute care providers; or

"(iv) combinations of post-acute providers.

"(B) FURTHER APPLICATION.—

"(i) IN GENERAL.—In carrying out paragraph (1), the Secretary shall apply bundled payments in a manner so as to include collaborative care networks and continuing care hospitals.

"(ii) COLLABORATIVE CARE NETWORK DEFINED.—For purposes of this subparagraph, the term 'collaborative care network' means a consortium of health care providers that provides a comprehensive range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality and efficiency of care, increase preventive services, and promote adherence to post-acute and follow-up care plans.

"(iii) CONTINUING CARE HOSPITAL DEFINED.—For purposes of this subparagraph, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long-term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).

"(b) SCOPE.—The pilot program under subsection (a) may include additional geographic areas and additional conditions which account for significant program spending, as defined by the Secretary. Nothing in this subsection shall be construed as limiting the number of hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program.

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

"(1) the demonstration program under section 1866C and pilot program under this section maintain or increase the quality of care received by individuals enrolled under this title; and

"(2) such demonstration program and pilot program reduce program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

"(d) CERTIFICATION.—For purposes of subsection (c), the Chief Actuary of the Centers for Medicare & Medicaid Services shall certify whether expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

"(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.

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

"(g) STUDY OF ADDITIONAL BUNDLING AND EPISODE-BASED PAYMENT FOR PHYSICIANS' SERVICES.—

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

"(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.".

(2) CONFORMING AMENDMENT.—Section 1866C(b) of the Social Security Act (42 U.S.C. 1395cc–3(b)) is amended by striking "The Secretary" and inserting "Subject to section 1866D, the Secretary".

SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV), by striking "and";

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

"(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;

"(VI) 2010, subject to clause (v), 0 percent; and".

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iv), by striking "Insofar as" and inserting "Subject to clause (vi), insofar as"; and

(2) by adding at the end the following new clause:

"(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—

"(I) IN GENERAL.—With respect to the case mix adjustments established in section 484.220(a) of title 42, Code of Federal Regulations, the Secretary shall apply, in 2010, the adjustment established in paragraph (3) of such section for 2011, in addition to applying the adjustment established in paragraph (2) for 2010.

"(II) CONSTRUCTION.—Nothing in this clause shall be construed as limiting the amount of adjustment for case mix for 2010 or 2011 if more recent data indicate an appropriate adjustment that is greater than the amount established in the section described in subclause (I).".

(b) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (III), by inserting "and before 2011" after "after the period described in subclause (II)"; and

(B) by inserting after subclause (III) the following new subclauses:

"(IV) Subject to clause (iii)(I), for 2011, such amount (or amounts) shall be adjusted by a uniform percentage determined to be appropriate by the Secretary based on analysis of factors such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant.

"(V) Subject to clause (iii)(II), for a year after 2011, such a amount (or amounts) shall be equal to the amount (or amounts) determined under this clause for the previous year, updated under subparagraph (B).."; and

(2) by adding at the end the following new clause:

"(iii) SPECIAL RULE IN CASE OF INABILITY TO EFFECT TIMELY REBASING.—

"(I) APPLICATION OF PROXY AMOUNT FOR 2011.—If the Secretary is not able to compute the amount (or amounts) under clause (i)(IV) so as to permit, on a timely basis, the application of such clause for 2011, the Secretary shall substitute for such amount (or amounts) 95 percent of the amount (or amounts) that would otherwise be specified under clause (i)(III) if it applied for 2011.

"(II) ADJUSTMENT FOR SUBSEQUENT YEARS BASED ON DATA.—If the Secretary applies subclause (I), the Secretary before July 1, 2011, shall compare the amount (or amounts) applied under such subclause with the amount (or amounts) that should have been applied under clause (i)(IV). The Secretary shall decrease or increase the prospective payment amount (or amounts) under clause (i)(V) for 2012 (or, at the Secretary's discretion, over a period of several years beginning with 2012) by the amount (if any) by which the amount (or amounts) applied under subclause (I) is greater or less, respectively, than the amount (or amounts) that should have been applied under clause (i)(IV).".

SEC. 1155. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATE FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

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

(2) in clause (v)(I), by inserting "(but not below 0)" after "reduced".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to home health market basket percentage increases for years beginning with 2010.

SEC. 1156. LIMITATION ON MEDICARE EXCEPTIONS TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking "and" at the end;

(B) in subparagraph (B), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).";

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking "and" at the end;

(B) in subparagraph (C), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(D) the hospital meets the requirements described in subsection (i)(1).";

(3) by amending subsection (f) to read as follows:

"(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

"(1) IN GENERAL.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

"(A) the covered items and services provided by the entity, and

"(B) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection

(a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

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

"(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (i)(1), the hospital shall—

"(A) submit to the Secretary an initial report, and periodic updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

"(B) require that any referring physician owner or investor discloses to the individual being referred, by a time that permits the individual to make a meaningful decision regarding the receipt of services, as determined by the Secretary, the ownership or investment interest, as applicable, of such referring physician in the hospital; and

"(C) disclose the fact that the hospital is partially or wholly owned by one or more physicians or has one or more physician investors—

"(i) on any public website for the hospital; and

"(ii) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health services furnished outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

"(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.";

(4) by amending subsection (g)(5) to read as follows:

"(5) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

"(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

"(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (f)(2)(B) or a hospital that is required, but fails, to meet a disclosure requirement of subsection (f)(2)(C) is subject to a civil money penalty of not more than $10,000 for each case in which disclosure is required to have been made.

"(C) APPLICATION.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(5) by adding at the end the following new subsection:

"(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—

"(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph are as follows:

"(A) PROVIDER AGREEMENT.—The hospital had—

"(i) physician ownership or investment on January 1, 2009; and

"(ii) a provider agreement under section 1866 in effect on such date.

"(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

"(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (2), the number of operating rooms, procedure rooms, or beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms, procedure rooms, or beds, respectively, as of such date.

"(D) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

"(i) Any ownership or investment interests that the hospital offers to a physician are not offered on more favorable terms than the terms offered to a person who is not in a position to refer patients or otherwise generate business for the hospital.

"(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

"(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

"(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

"(v) The investment interest of the owner or investor is directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained.

"(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

"(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to a person that is not a physician owner or investor.

"(viii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

"(E) PATIENT SAFETY.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to—

"(i) provide assessment and initial treatment for medical emergencies; and

"(ii) if the hospital lacks additional capabilities required to treat the emergency involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

"(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

"(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

"(A) PROCESS.—

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

"(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide persons and entities in the community in which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

"(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

"(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i). The Secretary may issue such regulations as interim final regulations.

"(B) FREQUENCY.—The process described in subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

"(C) PERMITTED INCREASE.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the

number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application of the most recent increase under such an exception).

"(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, or beds of a hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

"(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, or beds' means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

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

"(E) CONDITIONS FOR APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital—

"(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

"(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

"(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

"(iv) that is located in a State in which the average bed capacity in the State is estimated to be less than the national average bed capacity;

"(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

"(vi) that meets other conditions as determined by the Secretary.

"(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished).

"(G) PUBLICATION OF FINAL DECISIONS.—Not later than 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Internet website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

"(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the exception process under this paragraph, including the establishment of such process, and any determination made under such process.

"(3) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection and subsection (f)(2), the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

"(4) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits a patient and does not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

"(A) the hospital shall disclose such fact to the patient; and

"(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

"(5) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital's provider agreement if the hospital is not in compliance with regulations pursuant to section 1866.".

(b) VERIFYING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to verify compliance with the requirements described in subsections (i)(1) and (i)(4) of section 1877 of the Social Security Act, as added by subsection (a)(5). The Secretary may use unannounced site reviews of hospitals and audits to verify compliance with such requirements.

(c) IMPLEMENTATION.—

(1) FUNDING.—For purposes of carrying out the amendments made by subsection (a) and the provisions of subsection (b), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account $5,000,000 for each fiscal year beginning with fiscal year 2010. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the amendments made by subsection (a) and the provisions of subsection (b).

SEC. 1157. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC ADJUSTMENT FACTORS UNDER MEDICARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academy of Science to conduct a comprehensive empirical study, and provide recommendations as appropriate, on the accuracy of the geographic adjustment factors established under sections 1848(e) and 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(e), 11395ww(d)(3)).

(b) MATTERS INCLUDED.—Such study shall include an evaluation and assessment of the following with respect to such adjustment factors:

(1) Empirical validity of the adjustment factors.

(2) Methodology used to determine the adjustment factors.

(3) Measures used for the adjustment factors, taking into account—

(A) timeliness of data and frequency of revisions to such data;

(B) sources of data and the degree to which such data are representative of costs; and

(C) operational costs of providers who participate in Medicare.

(c) EVALUATION.—Such study shall, within the context of the United States health care marketplace, evaluate and consider the following:

(1) The effect of the adjustment factors on the level and distribution of the health care workforce and resources, including—

(A) recruitment and retention that takes into account workforce mobility between urban and rural areas;

(B) ability of hospitals and other facilities to maintain an adequate and skilled workforce; and

(C) patient access to providers and needed medical technologies.

(2) The effect of the adjustment factors on population health and quality of care.

(3) The effect of the adjustment factors on the ability of providers to furnish efficient, high value care.

(d) REPORT.—The contract under subsection (a) shall provide for the Institute of Medicine to submit, not later than one year after the date of the enactment of this Act, to the Secretary and the Congress a report containing results and recommendations of the study conducted under this section.

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

SEC. 1158. REVISION OF MEDICARE PAYMENT SYSTEMS TO ADDRESS GEOGRAPHIC INEQUITIES.

(a) REVISION OF MEDICARE PAYMENT SYSTEMS.—Taking into account the recommendations described in the report under section 1157, and notwithstanding the geographic adjustments that would otherwise apply under section 1848(e) and section 1886(d)(3)(E) of the Social Security Act ((42 U.S.C. 1395w-4, 1395ww(d)), the Secretary of Health and Human Services shall include in proposed rules applicable to the rulemaking cycle for payment systems for physicians' services and inpatient hospital services under sections 1848 and section 1886(d) of such Act, respectively, proposals (as the Secretary determines to be appropriate) to revise the geographic adjustment factors used in such systems. Such proposals' rules shall be contained in the next rulemaking cycle following the submission to the Secretary of the report described in section 1157.

(b) PAYMENT ADJUSTMENTS.—

(1) FUNDING FOR IMPROVEMENTS.—The Secretary shall use funds as provided under subsection (c) in making changes to the geographic adjustment factors

pursuant to subsection (a). In making such changes to such geographic adjustment factors, the Secretary shall ensure that the estimated increased expenditures resulting from such changes does not exceed the amounts provided under subsection (c).

(2) ENSURING FAIRNESS.—In carrying out this subsection, the Secretary shall not reduce the geographic adjustment below the factor that applied for such payment system in the payment year before such changes.

(c) FUNDING.—Amounts in the Medicare Improvement Fund under section 1898, as amended by section 1146, shall be available to the Secretary to make changes to the geographic adjustments factors as described in subsections (a) and (b) with respect to services furnished before January 1, 2014. No more than one-half of such amounts shall be available with respect to services furnished in any one payment year.

SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an agreement with the Institutes of Medicine of the National Academies (referred to in this section as the "Institute") to conduct a study on geographic variation in per capita health care spending among both the Medicare and privately insured populations. Such study shall include each of the following:

(1) An evaluation of the extent and range of such variation using various units of geographic measurement.

(2) The extent to which geographic variation can be attributed to differences in input prices, practice patterns, access to medical services, supply of medical services, socio-economic factors, and provider organizational models.

(3) The extent to which variations in spending are correlated with patient access to care, distribution of health care resources, and consensus-based measures of health care quality.

(4) The extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary treatment decisions are made that could be characterized as different from the best available medical evidence.

(5) An assessment of the degree to which variation cannot be explained by empirical evidence.

(6) Other factors the Institute deems appropriate.

(b) RECOMMENDATIONS.—Taking into account the findings under subsection (a), the Institute shall recommend strategies for addressing variation in per capita spending by promoting high-value care (as defined in subsection (e)). In making such recommendations, the Institute shall consider each of the following:

(1) Measurement and reporting on quality and population health.

(2) Reducing fragmented and duplicative care.

(3) Promoting the practice of evidence-based medicine.

(4) Empowering patients to make value-based care decisions.

(5) Leveraging the use of health information technology.

(6) The role of financial and other incentives.

(7) Other topics the Institute deems appropriate.

(c) SPECIFIC CONSIDERATIONS.—In making the recommendations under subsection (b), the Institute shall specifically address whether payment systems under title XVIII of the Social Security Act for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the Institute shall consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute finds that application of such a value index would significantly incentivize providers to furnish high-value care, it shall make specific recommendations on how such an index would be designed and implemented. In so doing, it should identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how payments and spending under such title would be affected by such an index.

(d) REPORT.— Not later than three years after the date of the enactment of this Act, the Institute shall submit to Congress a report containing findings and recommendations of the study conducted under this section.

(e) HIGH-VALUE CARE DEFINED.—For purposes of this section, the term "high-value care" means the efficient delivery of high quality, evidence-based, patient-centered care.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as are necessary to carry out this section. Such sums are authorized to remain available until expended.

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.

Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking "beginning with 2007" and inserting "for 2007, 2008, 2009, and 2010"; and

(B) by inserting after "(k)(1)" the following: ", or, beginning with 2011, 1/12 of the blended benchmark amount determined under subsection (n)(1)"; and

(2) by adding at the end the following new subsection:

"(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

"(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3) and (4), the term 'blended benchmark amount' means for an area—

"(A) for 2011 the sum of—

"(i) 2/3 of the applicable amount (as defined in subsection (k)) for the area and year; and

"(ii) 1/3 of the amount specified in paragraph (2) for the area and year;

"(B) for 2012 the sum of—

"(i) 1/3 of the applicable amount for the area and year; and

"(ii) 2/3 of the amount specified in paragraph (2) for the area and year; and

"(C) for a subsequent year the amount specified in paragraph (2) for the area and year.

"(2) SPECIFIED AMOUNT.—The amount specified in this paragraph for an area and year is the amount specified in subsection (c)(1)(D)(i) for the area and year adjusted (in a manner specified by the Secretary) to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4).

"(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in paragraph (2).

"(4) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.".

SEC. 1162. QUALITY BONUS PAYMENTS.

(a) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 1161, is amended—

(1) in subsection (j), by inserting "subject to subsection (o)," after "For purposes of this part,"; and

(2) by adding at the end the following new subsection:

"(o) QUALITY BASED PAYMENT ADJUSTMENT.—

"(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year beginning with 2011, the blended benchmark amount under subsection (n)(1) shall be increased—

"(A) for 2011, by 2.6 percent;

"(B) for 2012, by 5.3 percent; and

"(C) for a subsequent year, by 8.0 percent.

"(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

"(A) QUALIFYING PLAN.—The term 'qualifying plan' means, for a year and subject to paragraph (4), a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system established by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

"(B) QUALIFYING COUNTY.—The term 'qualifying county' means, for a year, a county—

"(i) that ranked within the lowest quartile of counties in the amount specified in subsection (n)(2) for the year specified by the Secretary under subparagraph (A); and

"(ii) for which, as of June of such specified year, of the Medicare Advantage eligible individuals residing in the county—

"(I) at least 50 percent of such individuals were enrolled in Medicare Advantage plans; and

"(II) of the residents so enrolled at least 50 percent of such individuals were enrolled in such plans with a quality ranking (based

on the quality ranking system established by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

"(3) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall provide for publication on the website for the Medicare program of the information described in the previous sentence.

"(4) AUTHORITY TO DISQUALIFY DEFICIENT PLANS.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan's compliance with rules for Medicare Advantage plans under this part.".

SEC. 1163. EXTENSION OF SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.

Section 1853(a)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)(ii) is amended—

(1) in the matter before subclause (I), by striking "through 2010" and inserting "and each subsequent year"; and

(2) in subclause (II)—

(A) by inserting "periodically" before "conduct an analysis";

(B) by inserting "on a timely basis" after "are incorporated"; and

(C) by striking "only for 2008, 2009, and 2010" and inserting "for 2008 and subsequent years".

SEC. 1164. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) 2 WEEK PROCESSING PERIOD FOR ANNUAL ENROLLMENT PERIOD (AEP).—Paragraph (3)(B) of section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(1) by striking "and" at the end of clause (iii);

(2) in clause (iv)—

(A) by striking "and succeeding years" and inserting ", 2008, 2009, and 2010"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new clause:

"(v) with respect to 2011 and succeeding years, the period beginning on November 1 and ending on December 15 of the year before such year.".

(b) ELIMINATION OF 3-MONTH ADDITIONAL OPEN ENROLLMENT PERIOD (OEP).—Effective for plan years beginning with 2011, paragraph (2) of such section is amended by striking subparagraph (C).

SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), by striking "January 1, 2010" and inserting "January 1, 2012"; and

(2) in clause (iii), by striking "the service area for the year" and inserting "the portion of the plan's service area for the year that is within the service area of a reasonable cost reimbursement contract".

SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EMPLOYER GROUP PLANS.

(a) IN GENERAL.—The first sentence of paragraph (2) of section 1857(i) of the Social Security Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: ", but only if 90 percent of the Medicare Advantage eligible individuals enrolled under such plan reside in a county in which the MA organization offers an MA local plan".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for plan years beginning on or after January 1, 2011, and shall not apply to plans which were in effect as of December 31, 2010.

SEC. 1167. IMPROVING RISK ADJUSTMENT FOR PAYMENTS.

(a) REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)) in predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries; and the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data.

(b) IMPROVEMENTS TO RISK ADJUSTMENT.—Not later than January 1, 2012, the Secretary shall implement necessary improvements to the risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)), taking into account the evaluation under subsection (a).

SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.

(a) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(b) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD

SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

(1) in subparagraph (A), by inserting before the period at the end the following: "with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option";

(2) in subparagraph (B)(i), by striking "or an actuarially equivalent level of cost-sharing as determined in this part"; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

"(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.".

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(7) of such Act is amended to read as follows:

"(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Advantage plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.".

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2011.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2011.

SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLLEES IN PLANS WITH ENROLLMENT SUSPENSION.

Section 1851(e)(4) of the Social Security Act (42 U.S.C. 1395w(e)(4)) is amended—

(1) in subparagraph (C), by striking at the end "or";

(2) in subparagraph (D)—

(A) by inserting ", taking into account the health or well-being of the individual" before the period; and

(B) by redesignating such subparagraph as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

"(D) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or".

SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21), as previously amended by this subtitle, is amended by adding at the end the following new subsection:

"(p) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

"(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year (beginning with 2011), for each MA plan contract, the medical loss ratio of the plan in the previous year.

"(2) SUBMISSION OF DATA.—

"(A) IN GENERAL.—Each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the medical loss ratio on a timely basis.

"(B) DATA FOR 2010 AND 2011.—The data submitted under subparagraph (A) for 2010 and for 2011 shall be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

"(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year, beginning with 2012, shall be submitted based on the standardized elements and definitions developed under paragraph (3).

"(3) DEVELOPMENT OF DATA REPORTING STANDARDS.—

"(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2012, of data necessary for the calculation of the medical loss ratio for MA plans. Not later than December 31, 2010, the Secretary shall publish a report describing the elements and definitions so developed.

"(B) CONSULTATION.—The Secretary shall consult with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

"(4) MEDICAL LOSS RATIO TO BE DEFINED.—For purposes of this part, the term 'medical loss ratio' has the meaning given such term by the Secretary, taking into account the meaning given such term by the Health Choices Commissioner under section 116 of the America's Affordable Health Choices Act of 2009.".

(b) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least .85—

"(A) the Secretary shall require the Medicare Advantage organization offering the plan to give enrollees a rebate (in the second succeeding contract year) of premiums under this part (or part B or part D, if applicable) by such amount as would provide for a benefits ratio of at least .85;

"(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

"(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.".

SEC. 1174. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after "section 1858(c))" the following: ", and data submitted with respect to risk adjustment under section 1853(a)(3)".

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act, as amended by section 1173, is amended by adding at the end the following new paragraph:

"(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

"(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall include terms that inform the organization of the provisions in subsection (d).

"(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.".

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2011.

SEC. 1175. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

"(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid by an MA organization under this subsection.".

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

"(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids under this section in the same manner as it applies to bids by an MA organization under such section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids for contract years beginning on or after January 1, 2011.

PART 3—TREATMENT OF SPECIAL NEEDS PLANS

SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN ENROLLMENT PERIOD OF INDIVIDUALS INTO CHRONIC CARE SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new subparagraph:

"(C) The plan does not enroll an individual on or after January 1, 2011, other than during an annual, coordinated open enrollment period or when at the time of the diagnosis of the disease or condition that qualifies the individual as an individual described in subsection (b)(6)(B)(iii).".

SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS PLANS TO RESTRICT ENROLLMENT.

(a) IN GENERAL.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking "January 1, 2011" and inserting "January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the America's Affordable Health Choices Act of 2009)".

(b) GRANDFATHERING OF CERTAIN PLANS.—

(1) PLANS DESCRIBED.—For purposes of section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), a plan described in this paragraph is a plan that had a contract with a State that had a State program to operate an integrated Medicaid-Medicare program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004.

(2) ANALYSIS; REPORT.—The Secretary of Health and Human Services shall provide, through a contract with an independent health services evaluation organization, for an analysis of the plans described in paragraph (1) with regard to the impact of such plans on cost, quality of care, patient satisfaction, and other subjects as specified by the Secretary. Not later than December 31, 2011, the Secretary shall submit to Congress a report on such analysis and shall include in such report such recommendations with regard to the treatment of such plans as the Secretary deems appropriate.

Subtitle E—Improvements to Medicare Part D

SEC. 1181. ELIMINATION OF COVERAGE GAP.

(a) IN GENERAL.—Section 1860D–2(b) of such Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking "paragraph (4)" and inserting "paragraphs (4) and (7)";

(2) in paragraph (4)(B)(i), by inserting "subject to paragraph (7)" after "purposes of this part"; and

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

"(7) PHASED-IN ELIMINATION OF COVERAGE GAP.—

"(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket threshold from the amounts otherwise computed until there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

"(B) INCREASE IN INITIAL COVERAGE LIMIT.—For a year beginning with 2011, the initial coverage limit otherwise computed without regard to this paragraph shall be increased by ½ of the cumulative phase-in percentage (as defined in subparagraph (D)(ii) for the year) times the out-of-pocket gap amount (as defined in subparagraph (E)) for the year.

"(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—For a year beginning with 2011, the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by ½ of the cumulative

phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75.

"(D) PHASE–IN.—For purposes of this paragraph:

"(i) ANNUAL PHASE-IN PERCENTAGE.—The term 'annual phase-in percentage' means—

"(I) for 2011, 13 percent;

"(II) for 2012, 2013, 2014, and 2015, 5 percent;

"(III) for 2016 through 2018, 7.5 percent; and

"(IV) for 2019 and each subsequent year, 10 percent.

"(ii) CUMULATIVE PHASE-IN PERCENTAGE.—The term 'cumulative phase-in percentage' means for a year the sum of the annual phase-in percentage for the year and the annual phase-in percentages for each previous year beginning with 2011, but in no case more than 100 percent.

"(E) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

"(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

"(ii) the sum of—

"(I) the annual deductible under paragraph (1) for the year; and

"(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.".

(b) REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR FULL-BENEFIT DUAL ELIGIBLES.—

(1) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(A) in subsection (e)(1), in the matter before subparagraph (A), by inserting "and subsection (f)" after "this subsection"; and

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

"(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

"(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

"(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2010, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2010, to any full-benefit dual eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA organization under part C for such period. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3).

"(3) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

"(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer and dispensed to a full-benefit dual eligible individual, shall be equal to the product of—

"(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period (as reported under section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3)); and

"(ii) the amount (if any) by which—

"(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

"(II) the average Medicare drug program full-benefit dual eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

"(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period—

"(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section

1927(b) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

"(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

"(C) AVERAGE MEDICARE DRUG PROGRAM FULL-BENEFIT DUAL ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program full-benefit dual eligible rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

"(i) the product, for each such sponsor or organization, of—

"(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to full-benefit dual eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not full-benefit dual eligible individuals; and

"(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA–PD organization; divided by

"(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA–PD organizations.

"(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

"(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

"(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

"(A) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL.—The term 'full-benefit dual eligible individual' has the meaning given such term in section 1935(c)(6).

"(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).".

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURES RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

"(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

"(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

"(B) REPORT FORM AND CONTENTS.—Not later than 60 days after the end of each rebate period (as defined in section 1860D–2(f)(6)(B)) within such a contract year to which such section applies, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

"(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to full-benefit dual eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

"(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

"(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to full-benefit dual eligible Medicare drug plan enrollees and PDP enrollees who are not full-benefit dual eligible Medicare drug plan enrollees; and

"(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program full-benefit dual eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

"(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

"(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

"(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

"(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

"(iii) clause (iv) of such subparagraph shall not apply.

"(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

"(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

"(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

"(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

"(D) REPORTING REQUIREMENT RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).".

(3) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of such Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

"(6) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).".

SEC. 1182. DISCOUNTS FOR CERTAIN PART D DRUGS IN ORIGINAL COVERAGE GAP.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102), as amended by section 1181, is amended—

(1) in subsection (b)(4)(C)(ii), by inserting "subject to subsection (g)(2)(C)," after "(ii)";

(2) in subsection (e)(1), in the matter before subparagraph (A), by striking "subsection (f)" and inserting "subsections (f) and (g)" after "this subsection"; and

(3) by adding at the end the following new subsection:

"(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

"(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect for all qualifying drugs (as defined in paragraph (5)(A)) a discount agreement described in paragraph (2).

"(2) DISCOUNT AGREEMENT.—

"(A) PERIODIC DISCOUNTS.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(A)) of the manufacturer dispensed to a qualifying enrollee after December 31, 2010, insofar as the individual is in the original gap in coverage (as defined in paragraph (5)(E)).

"(B) DISCOUNT AGREEMENT.—Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement, including terms and conditions relating to compliance, similar to the terms and conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1927(b), except that—

"(i) discounts shall be applied under this subsection to prescription drug plans and MA–PD plans instead of State plans under title XIX;

"(ii) PDP sponsors and MA organizations shall be responsible, instead of States, for provision of necessary utilization information to drug manufacturers; and

"(iii) sponsors and MA organizations shall be responsible for reporting information on drug-component negotiated price, instead of other manufacturer prices.

"(C) COUNTING DISCOUNT TOWARD TRUE OUT-OF-POCKET COSTS.—Under the discount agreement, in applying subsection (b)(4), with regard to subparagraph (C)(i) of such subsection, if a qualified enrollee purchases the qualified drug insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the amount of the discount under the agreement shall be treated and counted as costs incurred by the plan enrollee.

"(3) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price (as defined in paragraph (5)(C)) for qualifying drugs for the period involved.

"(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

"(A) insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the sponsor or plan shall provide the discount to the enrollee at the time the enrollee pays for the drug; and

"(B) insofar as the enrollee is in the portion of the original gap in coverage (as defined in paragraph (5)(E)) that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

"(5) DEFINITIONS.—In this subsection:

"(A) QUALIFYING DRUG.—The term 'qualifying drug' means, with respect to a prescription drug plan or MA–PD plan, a drug or biological product that—

"(i)(I) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application;

"(II) is a drug that was originally marketed under an original new drug application approved by the Food and Drug Administration; or

"(III) is a biological product as approved under Section 351(a) of the Public Health Services Act;

"(ii) is covered under the formulary of the plan; and

"(iii) is dispensed to an individual who is in the original gap in coverage.

"(B) QUALIFYING ENROLLEE.—The term 'qualifying enrollee' means an individual enrolled in a prescription drug plan or MA–PD plan other than such an individual who is a subsidy-eligible individual (as defined in section 1860D–14(a)(3)).

"(C) DRUG-COMPONENT NEGOTIATED PRICE.—The term 'drug-component negotiated price' means, with respect to a qualifying drug, the negotiated

price (as defined in subsection (d)(1)(B)), as determined without regard to any dispensing fee, of the drug under the prescription drug plan or MA–PD plan involved.

"(D) ACTUAL GAP IN COVERAGE.—The term 'actual gap in coverage' means the gap in prescription drug coverage that occurs between the initial coverage limit (as modified under subparagraph (B) of subsection (b)(7)) and the annual out-of-pocket threshold (as modified under subparagraph (C) of such subsection).

"(E) ORIGINAL GAP IN COVERAGE.—The term 'original in gap coverage' means the gap in prescription drug coverage that would occur between the initial coverage limit (described in subsection (b)(3)) and the out-of-pocket threshold (as defined in subsection (b)(4))(B) if subsection (b)(7) did not apply.".

SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.

(a) PART D SUBMISSION.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)), as amended by section 172(a)(1) of Public Law 110–275, is amended by striking paragraph (5) and redesignating paragraph (6) and paragraph (7), as added by section 1181(b)(2), as paragraph (5) and paragraph (6), respectively.

(b) SUBMISSION TO MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)), as added by section 171(b) of Public Law 110–275 and amended by section 172(a)(2) of such Public Law and section 1181 of this Act, is amended by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C) respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning with 2010.

SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii)—

(A) by striking "such costs shall be treated as incurred only if" and inserting "subject to clause (iii), such costs shall be treated as incurred only if";

(B) by striking ", under section 1860D–14, or under a State Pharmaceutical Assistance Program"; and

(C) by striking the period at the end and inserting "; and"; and

(3) by inserting after clause (ii) the following new clause:

"(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

"(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES THAT ADVERSELY IMPACT AN ENROLLEE.

(a) IN GENERAL.—Section 1860D–1(b)(3) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)) is amended by adding at the end the following new subparagraph:

"(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

"(i) IN GENERAL.—Except as provided in clause (ii), in the case of an individual enrolled in a prescription drug plan (or MA–PD plan) who has been prescribed and is using a covered part D drug while so enrolled, if the formulary of the plan is materially changed (other than at the end of a contract year) so to reduce the coverage (or increase the cost-sharing) of the drug under the plan.

"(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management applied to—

"(I) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 210.57(c)(1) of title 21, Code of Federal Regulations (or a successor regulation); or

"(II) a drug required under subsection (c)(2) of section 505–1 of the Federal Food, Drug, and Cosmetic Act to have a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 2011.

Subtitle F—Medicare Rural Access Protections

SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS. .

(a) ADDITIONAL TELEHEALTH SITE.—

(1) IN GENERAL.—Paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new subclause:

"(IX) A renal dialysis facility."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) in the heading, by adding at the end the following: "TELEHEALTH ADVISORY COMMITTEE"; and

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

"(c) TELEHEALTH ADVISORY COMMITTEE.—

"(1) IN GENERAL.—The Secretary shall appoint a Telehealth Advisory Committee (in this subsection referred to as the 'Advisory Committee') to make recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services regarding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

"(2) MEMBERSHIP; TERMS.—

"(A) MEMBERSHIP.—

"(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

"(I) 5 shall be practicing physicians;

"(II) 2 shall be practicing non-physician health care practitioners; and

"(III) 2 shall be administrators of telehealth programs.

"(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

"(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

"(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

"(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

"(IV) take into account the recommendations of stakeholders.

"(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

"(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

"(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

"(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee."

(2) FOLLOWING RECOMMENDATIONS.—Section 1834(m)(4)(F) of such Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

"(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall

take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented."

(3) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (1) notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

(c) CREDENTIALING TELEMEDICINE PRACTITIONERS.—Section 1834(m) of such Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new paragraph:

"(5) HOSPITAL CREDENTIALING OF TELEMEDICINE PRACTITIONERS.—A telemedicine practitioner that is credentialed by a hospital in compliance with the Joint Commission Standards for Telemedicine shall be considered in compliance with conditions of participation and reimbursement credentialing requirements under this title for telemedicine services.".

SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking '"2010" and inserting "2012"; and

(B) in the second sentence, by striking "or 2009" and inserting ", 2009, 2010, or 2011"; and

(2) in subclause (III), by striking "January 1, 2010" and inserting "January 1, 2012".

SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.

Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking "September 30, 2009" and inserting "September 30, 2011".

SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "before January 1, 2010" and inserting "before January 1, 2012".

SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 1008 (Public Law 110–275), is amended by striking "and 2009" and inserting "2009, 2010, and 2011".

SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

(a) IN GENERAL.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "before January 1, 2010" and inserting "before January 1, 2012"; and

(B) in each of clauses (i) and (ii), by striking "before January 1, 2010" and inserting "before January 1, 2012".

(b) AIR AMBULANCE IMPROVEMENTS.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking "ending on December 31, 2009" and inserting "ending on December 31, 2011".

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

(a) APPLICATION OF HIGHEST LEVEL PERMITTED UNDER LIS TO ALL SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–14(a)(1) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)) is amended in the matter before subparagraph (A), by inserting "(or, beginning with 2012, paragraph (3)(E))" after "paragraph (3)(D)".

(2) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of such Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

(A) by striking "and" at the end of subclause (I);

(B) in subclause (II), by inserting "(before 2012)" after "subsequent year";

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

"(III) for 2012, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

"(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year."; and

(E) in the last sentence, by inserting "or (IV)" after "subclause (II)".

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

(A) by striking "effective beginning with January 1, 2010" and inserting "effective for the period beginning with January 1, 2010, and ending with December 31, 2011"; and

(B) by inserting before the period at the end the following: "or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations for income-related subsidies and medicare cost-sharing furnished for periods beginning on or after January 1, 2012.

SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(1) by striking "INSTITUTIONALIZED INDIVIDUALS.—In" and inserting "ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

"(I) INSTITUTIONALIZED INDIVIDUALS.—In"; and

(2) by adding at the end the following new subclause:

"(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1932, or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—

(1) IN GENERAL.—Clause (iii) of section 1860D–14(a)(3)(E) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is amended to read as follows:

"(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

"(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

"(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning January 1, 2010.

(b) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—For provision authorizing disclosure of return information to facilitate identification of individuals likely to be ineligible for low-income subsidies under Medicare prescription drug program, see section 1801.

SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIMBURSEMENTS FOR RETROACTIVE LOW INCOME SUBSIDY ENROLLMENT.

(a) IN GENERAL.—In the case of a retroactive LIS enrollment beneficiary who is enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the beneficiary (or any eligible third party) is entitled to reimbursement by the plan for covered drug costs incurred by the beneficiary during the retroactive coverage period of the beneficiary in accordance with subsection (b) and in the case of such a beneficiary described in subsection (c)(4)(A)(i), such reimbursement shall be made automatically by the plan upon receipt of appropriate notice the beneficiary is eligible for assistance described in such subsection (c)(4)(A)(i) without further information required to be filed with the plan by the beneficiary.

(b) ADMINISTRATIVE REQUIREMENTS RELATING TO REIMBURSEMENTS.—

(1) LINE-ITEM DESCRIPTION.—Each reimbursement made by a prescription drug plan or MA–PD plan under subsection (a) shall include a line-item description of the items for which the reimbursement is made.

(2) TIMING OF REIMBURSEMENTS.—A prescription drug plan or MA–PD plan must make a reimbursement under subsection (a) to a retroactive LIS enrollment beneficiary, with respect to a claim, not later than 45 days after—

(A) in the case of a beneficiary described in subsection (c)(4)(A)(i), the date on which the plan receives notice from the Secretary that the beneficiary is eligible for assistance described in such subsection; or

(B) in the case of a beneficiary described in subsection (c)(4)(A)(ii), the date on which the beneficiary files the claim with the plan.

(3) REPORTING REQUIREMENT.—For each month beginning with January 2011, each prescription drug plan and each MA–PD plan shall report to the Secretary the following:

(A) The number of claims the plan has readjudicated during the month due to a beneficiary becoming retroactively eligible for subsidies available under section 1860D–14 of the Social Security Act.

(B) The total value of the readjudicated claim amount for the month.

(C) The Medicare Health Insurance Claims Number of beneficiaries for whom claims were readjudicated.

(D) For the claims described in subparagraphs (A) and (B), an attestation to the Administrator of the Centers for Medicare & Medicaid Services of the total amount of reimbursement the plan has provided to beneficiaries for premiums and cost-sharing that the beneficiary overpaid for which the plan received payment from the Centers for Medicare & Medicaid Services.

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

(1) COVERED DRUG COSTS.—The term "covered drug costs" means, with respect to a retroactive LIS enrollment beneficiary enrolled under a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title), the amount by which—

(A) the costs incurred by such beneficiary during the retroactive coverage period of the beneficiary for covered part D drugs, premiums, and cost-sharing under such title; exceeds

(B) such costs that would have been incurred by such beneficiary during such period if the beneficiary had been both enrolled in the plan and recog-

nized by such plan as qualified during such period for the low income subsidy under section 1860D–14 of the Social Security Act to which the individual is entitled.

(2) ELIGIBLE THIRD PARTY.—The term "eligible third party" means, with respect to a retroactive LIS enrollment beneficiary, an organization or other third party that is owed payment on behalf of such beneficiary for covered drug costs incurred by such beneficiary during the retroactive coverage period of such beneficiary.

(3) RETROACTIVE COVERAGE PERIOD.—The term "retroactive coverage period" means—

(A) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(i), the period—

(i) beginning on the effective date of the assistance described in such paragraph for which the individual is eligible; and

(ii) ending on the date the plan effectuates the status of such individual as so eligible; and

(B) with respect to a retroactive LIS enrollment beneficiary described in paragraph (4)(A)(ii), the period—

(i) beginning on the date the individual is both entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act and eligible for medical assistance under a State plan under title XIX of such Act; and

(ii) ending on the date the plan effectuates the status of such individual as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act).

(4) RETROACTIVE LIS ENROLLMENT BENEFICIARY.—

(A) IN GENERAL.—The term "retroactive LIS enrollment beneficiary" means an individual who—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act (or an MA–PD plan under part C of such title) and subsequently becomes eligible as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act), an individual receiving a low-income subsidy under section 1860D–14 of such Act, an individual receiving assistance under the Medicare Savings Program implemented under clauses (i), (iii), and (iv) of section 1902(a)(10)(E) of such Act, or an individual receiving assistance under the supplemental security income program under section 1611 of such Act; or

(ii) subject to subparagraph (B)(i), is a full-benefit dual eligible individual (as defined in section 1935(c)(6) of such Act) who is automatically enrolled in such a plan under section 1860D–1(b)(1)(C) of such Act.

(B) EXCEPTION FOR BENEFICIARIES ENROLLED IN RFP PLAN.—

(i) IN GENERAL.—In no case shall an individual described in subparagraph (A)(ii) include an individual who is enrolled, pursuant to a RFP contract described in clause (ii), in a prescription drug plan offered by the sponsor of such plan awarded such contract.

(ii) RFP CONTRACT DESCRIBED.—The RFP contract described in this section is a contract entered into between the Secretary and a sponsor of a prescription drug plan pursuant to the Centers for Medicare & Medicaid Services' request for proposals issued on February 17, 2009, relating to Medicare part D retroactive coverage for certain low income beneficiaries, or a similar subsequent request for proposals.

SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is amended by adding after "PDP region" the following: "or through use of an intelligent assignment process that is designed to maximize the access of such individual to necessary prescription drugs while minimizing costs to such individual and to the program under this part to the greatest extent possible. In the case the Secretary enrolls such individuals through use of an intelligent assignment process, such process shall take into account the extent to which prescription drugs necessary for the individual are covered in the case of a PDP sponsor of a prescription drug plan that uses a formulary, the use of prior authorization or other restrictions on access to coverage of such prescription drugs by such a sponsor, and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary"

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for contract years beginning with 2012.

SEC. 1206. SPECIAL ENROLLMENT PERIOD AND AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.

(a) SPECIAL ENROLLMENT PERIOD.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended to read as follows:

"(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.".

(b) AUTOMATIC ENROLLMENT.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended by adding at the end the following new subparagraph:

"(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the assignment process described in subparagraph (C) to such individual in the same manner as such assignment process applies to a part D eligible individual described in such subparagraph (C). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidy determinations made for months beginning with January 2011.

SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO REBATE IN CALCULATION OF LOW INCOME SUBSIDY BENCHMARK.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting before the period the following: "before the application of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to subsidy determinations made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(F) The extent to which providers under parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make available language services for beneficiaries with limited English proficiency.

(G) The nature and type of language services provided by States under title XIX of the Social Security Act and the extent to which such services could be utilized by beneficiaries and providers under title XVIII of such Act.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in paragraph (2)(A) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors or agencies, or both);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

(5) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act"), shall not apply for purposes of carrying out this subsection.

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

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking "or" at the end of subparagraph (F);

(2) by adding "or" at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;".

SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Not later than 6 months after the date of the completion of the study described in section 1221(a), the Secretary, acting through the Centers for Medicare & Medicaid Services, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration the Secretary shall take into consideration the results of the study conducted under section 1221(a) and adjust, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are in the greatest need of language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) at least 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) at least 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) at least 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors, variations in—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions, as defined by the Secretary; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (e).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than "very well" from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of such individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of limited English proficient individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e) and may be modified annually at the discretion of the Secretary. If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation serv-

ices) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery;

(2) ensure the linguistic competence of bilingual providers;

(3) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(4) notify Medicare beneficiaries of their right to receive language services in their primary language;

(5) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(6) ensure that—

(A) primary language data are collected for recipients of language services; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. Each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(f) NO COST SHARING.—Limited English proficient Medicare beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) Recommendations, if any, regarding the extension of such project to the entire Medicare program.

(h) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $16,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 1224. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term "bilingual" with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term "competent interpreter services" means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term "competent translation services" means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term "effective communication" means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms "interpreting" and "interpretation" mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term "health care services" means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term "health care-related services" means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term "language access" means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term "language services" means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term "limited English proficient" or "LEP" with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE BENEFICIARY.—The term "Medicare beneficiary" means an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title.

(12) MEDICARE PROGRAM.—The term "Medicare program" means the programs under parts A through D of title XVIII of the Social Security Act.

(13) SERVICE PROVIDER.—The term "service provider" includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

Subtitle C—Miscellaneous Improvements

SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS PROCESS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking "December 31, 2009" and inserting "December 31, 2011".

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting "(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))" before ", with the thirty-sixth month".

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1395o) is amended—

(i) by striking "Every individual who" and inserting "(a) IN GENERAL.—Every individual who"; and

(ii) by adding at the end the following new subsection:

"(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

"(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

"(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

"(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

"(C) The provision of such drugs shall be subject to the application of—

"(i) the deductible under section 1833(b); and

"(ii) the coinsurance amount applicable for such drugs (as determined under this part).

"(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

"(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

"(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

"(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.".

(C) TECHNICAL AMENDMENT TO CORRECT DUPLICATE SUBSECTION DESIGNATION.—Subsection (c) of section 226A of such Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: "With regard to immunosuppressive drugs furnished on or after the date of the enactment of the America's Affordable Health Choices Act of 2009, this subparagraph shall be applied without regard to any time limitation.".

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of such Act is further amended—

(1) in subsection (b)(14)(B)(iii), by inserting ", including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics)," after "other drugs and biologicals";

(2) in subsection (b)(14)(E)(ii)—

(A) in the first sentence—

(i) by striking "a one-time election to be excluded from the phase-in" and inserting "an election, with respect to 2011, 2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)"; and

(ii) by adding before the period at the end the following: "for such year and for each subsequent year during the phase-in described in clause (i)"; and

(B) in the second sentence—

(i) by striking "January 1, 2011" and inserting "the first date of such year"; and

(ii) by inserting "and at a time" after "form and manner"; and

(3) in subsection (h)(4)(E), by striking "lesser" and inserting "greater".

SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)—

(i) by striking "and" at the end of subparagraph (DD);

(ii) by adding "and" at the end of subparagraph (EE); and

(iii) by adding at the end the following new subparagraph:

"(FF) advance care planning consultation (as defined in subsection (hhh)(1));"; and

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

"Advance Care Planning Consultation

"(hhh)(1) Subject to paragraphs (3) and (4), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

"(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

"(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

"(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

"(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act of 1965).

"(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

"(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

"(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

"(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

"(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

"(ii) The Secretary shall limit the requirement for explanations under clause (i) to consultations furnished in a State—

"(I) in which all legal barriers have been addressed for enabling orders for life sustaining treatment to constitute a set of medical orders respected across all care settings; and

"(II) that has in effect a program for orders for life sustaining treatment described in clause (iii).

"(iii) A program for orders for life sustaining treatment for a States described in this clause is a program that—

"(I) ensures such orders are standardized and uniquely identifiable throughout the State;

"(II) distributes or makes accessible such orders to physicians and other health professionals that (acting within the scope of the professional's authority under State law) may sign orders for life sustaining treatment;

"(III) provides training for health care professionals across the continuum of care about the goals and use of orders for life sustaining treatment; and

"(IV) is guided by a coalition of stakeholders includes representatives from emergency medical services, emergency department physicians or nurses, state long-term care association, state medical association, state surveyors, agency responsible for senior services, state department of health, state hospital association, home health association, state bar association, and state hospice association.

"(2) A practitioner described in this paragraph is—

"(A) a physician (as defined in subsection (r)(1)); and

"(B) a nurse practitioner or physician assistant who has the authority under State law to sign orders for life sustaining treatments.

"(3)(A) An initial preventive physical examination under subsection (WW), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

"(B) An advance care planning consultation with respect to an individual may be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

"(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

"(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

"(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order, including a nurse practitioner or physician assistant) and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care;

"(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

"(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and

"(iv) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

"(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

"(i) the intensity of medical intervention if the patient is pulse less, apneic, or has serious cardiac or pulmonary problems;

"(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

"(iii) the use of antibiotics; and

"(iv) the use of artificially administered nutrition and hydration.".

(2) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting "(2)(FF)," after "(2)(EE),".

(3) FREQUENCY LIMITATION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (N), by striking "and" at the end;

(ii) in subparagraph (O) by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;"; and

(B) in paragraph (7), by striking "or (K)" and inserting "(K), or (P)".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

(b) EXPANSION OF PHYSICIAN QUALITY REPORTING INITIATIVE FOR END OF LIFE CARE.—

(1) PHYSICIAN'S QUALITY REPORTING INITIATIVE.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)) is amended by adding at the end the following new subparagraph:

"(E) PHYSICIAN'S QUALITY REPORTING INITIATIVE.—

"(i) IN GENERAL.—For purposes of reporting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to the extent that measures are available, the Secretary shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.

"(ii) PROPOSED SET OF MEASURES.—The Secretary shall publish in the Federal Register proposed quality measures on end of life care and advanced care planning that the Secretary determines are described in subparagraph (A) and would be appropriate for eligible professionals to use to submit data to the Secretary. The Secretary shall provide for a period of public comment on such set of measures before finalizing such proposed measures.".

(c) INCLUSION OF INFORMATION IN MEDICARE & YOU HANDBOOK.—

(1) MEDICARE & YOU HANDBOOK.—

(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall update the online version of the Medicare & You Handbook to include the following:

(i) An explanation of advance care planning and advance directives, including—

(I) living wills;

(II) durable power of attorney;

(III) orders of life-sustaining treatment; and

(IV) health care proxies.

(ii) A description of Federal and State resources available to assist individuals and their families with advance care planning and advance directives, including—

(I) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 93001 et seq.);

(II) website links or addresses for State-specific advance directive forms; and

(III) any additional information, as determined by the Secretary.

(B) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in subparagraph (A) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 1 year after the date of the enactment of this Act.

SEC. 1234. PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF LIMITED ENROLLMENT PENALTY FOR TRICARE BENEFICIARIES.

(a) PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

"(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

"(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls or, at the option of the individual, on the first day of the second month following the last month of the individual's initial enrollment period.

"(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrollment period described in paragraph (2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made on or after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—

(1) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking "section 1837(i)(4)" and inserting "subsection (i)(4) or (l) of section 1837".

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendment made by paragraph (1) shall apply with respect to elections made on or after the date of the enactment of this Act.

(B) REBATES FOR CERTAIN DISABLED AND ESRD BENEFICIARIES.—

(i) IN GENERAL.—With respect to premiums for months on or after January 2005 and before the month of the enactment of this Act, no increase in the premium shall be effected for a month in the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act under section 226(b) or 226A of such Act, and who is eligible to enroll, but who has elected not to enroll (or to be deemed enrolled), during the individual's initial enrollment period, and who enrolls under this part within the 12-month period that begins on the first day of the month after the month of notification of entitlement under this part.

(ii) CONSULTATION WITH DEPARTMENT OF DEFENSE.—The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in this paragraph.

(iii) REBATES.—The Secretary of Health and Human Services shall establish a method for providing rebates of premium increases paid for months on or after January 1, 2005, and before the month of the enactment of this Act for which a penalty was applied and collected.

SEC. 1235. EXCEPTION FOR USE OF MORE RECENT TAX YEAR IN CASE OF GAINS FROM SALE OF PRIMARY RESIDENCE IN COMPUTING PART B INCOME-RELATED PREMIUM.

(a) IN GENERAL.—Section 1839(i)(4)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395r(i)(4)(C)(ii)(II)) is amended by inserting "sale of primary residence," after "divorce of such individual,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums and payments for years beginning with 2011.

SEC. 1236. DEMONSTRATION PROGRAM ON USE OF PATIENT DECISIONS AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a shared decision making demonstration program (in this subsection referred to as the "program") under the Medicare program using patient decision aids to meet the objective of improving the understanding by Medicare beneficiaries of their medical treatment options, as compared to comparable Medicare beneficiaries who do not participate in a shared decision making process using patient decision aids.

(b) SITES.—

(1) ENROLLMENT.—The Secretary shall enroll in the program not more than 30 eligible providers who have experience in implementing, and have invested in the necessary infrastructure to implement, shared decision making using patient decision aids.

(2) APPLICATION.—An eligible provider seeking to participate in the program shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(3) PREFERENCE.—In enrolling eligible providers in the program, the Secretary shall give preference to eligible providers that—

(A) have documented experience in using patient decision aids for the conditions identified by the Secretary and in using shared decision making;

(B) have the necessary information technology infrastructure to collect the information required by the Secretary for reporting purposes; and

(C) are trained in how to use patient decision aids and shared decision making.

(c) FOLLOW-UP COUNSELING VISIT.—

(1) IN GENERAL.—An eligible provider participating in the program shall routinely schedule Medicare beneficiaries for a counseling visit after the viewing of such a patient decision aid to answer any questions the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their medical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits provided to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services; and

(B) of a single payment amount for such service that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eligible provider such as would be made under the applicable payment systems to that provider for similar covered services.

(d) COSTS OF AIDS.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider's practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of health care services, and on improving the quality of life of such beneficiaries.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term "eligible provider" means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids.

(2) PATIENT DECISION AID.—The term "patient decision aid" means an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

(3) SHARED DECISION MAKING.—The term "shared decision making" means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

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

SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as added by section 1152(f) of this Act, the following new section:

"ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

"SEC. 1866E. (a) IN GENERAL.—The Secretary shall conduct a pilot program (in this section referred to as the 'pilot program') to test different payment incentive models, including (to the extent practicable) the specific payment incentive models described in subsection (c), designed to reduce the growth of expenditures and im-

prove health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

"(1) promote accountability for a patient population and coordinate items and services under parts A and B;

"(2) encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and

"(3) reward physician practices and other physician organizational models for the provision of high quality and efficient health care services.

"(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOS).—

"(1) QUALIFYING ACO DEFINED.—In this section:

"(A) IN GENERAL.—The terms 'qualifying accountable care organization' and 'qualifying ACO' mean a group of physicians or other physician organizational model (as defined in subparagraph (D)) that—

"(i) is organized at least in part for the purpose of providing physicians' services; and

"(ii) meets such criteria as the Secretary determines to be appropriate to participate in the pilot program, including the criteria specified in paragraph (2).

"(B) INCLUSION OF OTHER PROVIDERS.—Nothing in this subsection shall be construed as preventing a qualifying ACO from including a hospital or any other provider of services or supplier furnishing items or services for which payment may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

"(C) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services.

"(D) OTHER PHYSICIAN ORGANIZATIONAL MODEL.—The term 'other physician organization model' means, with respect to a qualifying ACO any model of organization under which physicians enter into agreements with other providers for the purposes of participation in the pilot program in order to provide high quality and efficient health care services and share in any incentive payments under such program

"(E) OTHER SERVICES.—Nothing in this paragraph shall be construed as preventing a qualifying ACO from furnishing items or services, for which payment may not be made under this title, for purposes of achieving performance goals under the pilot program.

"(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for an organized group of physicians to be a qualifying ACO:

"(A) The group has a legal structure that would allow the group to receive and distribute incentive payments under this section.

"(B) The group includes a sufficient number of primary care physicians (regardless of specialty) for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary).

"(C) The group reports on quality measures in such form, manner, and frequency as specified by the Secretary (which may be for the group, for providers of services and suppliers, or both).

"(D) The group reports to the Secretary (in a form, manner and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the pilot program.

"(E) The group provides notice to applicable beneficiaries regarding the pilot program (as determined appropriate by the Secretary).

"(F) The group contributes to a best practices network or website, that shall be maintained by the Secretary for the purpose of sharing strategies on quality improvement, care coordination, and efficiency that the groups believe are effective.

"(G) The group utilizes patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring of ongoing care management plan.

"(H) The group meets other criteria determined to be appropriate by the Secretary.

"(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The specific payment incentive models described in this subsection are the following:

"(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the 'performance target model'):

"(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment shall be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B.

"(B) COMPUTATION OF PERFORMANCE TARGET.—

"(i) IN GENERAL.—The Secretary shall establish a performance target for each qualifying ACO comprised of a base amount (described in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established on a per capita basis, as the Secretary determines to be appropriate.

"(ii) BASE AMOUNT.—For purposes of clause (i), the base amount in this subparagraph is equal to the average total payments (or allowed charges) under parts A and B (and may include part D, if the Secretary determines appropriate) for applicable beneficiaries for whom the qualifying ACO furnishes items and services in a base period determined by the Secretary. Such base amount may be determined on a per capita basis.

"(iii) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the period of the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries (as determined by the Secretary). Such adjustment factor may be determined as an amount or rate, may be determined on a national, regional, local, or organization-specific basis, and may be determined on a per capita basis. Such adjustment factor also may be adjusted for risk as determined appropriate by the Secretary.

"(iv) REBASING.—Under this model the Secretary shall periodically rebase the base expenditure amount described in clause (ii).

"(C) MEETING TARGET.—

"(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meet or exceeds annual quality and performance targets for a year shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year relative are estimated to be below the performance target for such year, as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

"(ii) LIMITATION.— The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this section were not implemented.

"(D) REPORTING AND OTHER REQUIREMENTS.—In carrying out such model, the Secretary may (as the Secretary determines to be appropriate) incorporate reporting requirements, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

"(2) PARTIAL CAPITATION MODEL.—

"(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a 'partial capitation model') is a model in which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to a qualifying ACO for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended

for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

"(3) OTHER PAYMENT MODELS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency.

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

"(d) APPLICABLE BENEFICIARIES.—

"(1) IN GENERAL.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying ACO, an individual who—

"(A) is enrolled under part B and entitled to benefits under part A;

"(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

"(C) meets such other criteria as the Secretary determines appropriate, which may include criteria relating to frequency of contact with physicians in the ACO

"(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying ACO.

"(e) IMPLEMENTATION.—

"(1) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

"(2) WAIVER.—The Secretary may waive such provisions of this title (including section 1877) and title XI in the manner the Secretary determines necessary in order implement the pilot program.

"(3) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results to qualifying ACOs under the pilot program at least annually.

"(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) the elements, parameters, scope, and duration of the pilot program;

"(B) the selection of qualifying ACOs for the pilot program;

"(C) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings;

"(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

"(E) decisions about the extension of the program under subsection (g), expansion of the program under subsection (h) or extensions under subsection (i).

"(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

"(f) EVALUATION; MONITORING.—

"(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

"(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the 'Stark law').

"(g) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

"(1) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter for six years, the Secretary shall submit to Congress and make publicly available a report on the use of authorities under the pilot program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under this title.

"(2) EXTENSION.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate if—

"(A) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or

"(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

"(3) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

"(h) EXPANSION TO ADDITIONAL ACOS.—

"(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE MODELS.—Subject to the evaluation described in subsection (f), the Secretary may enter into agreements under the pilot program with additional qualifying ACOs to further test and refine payment incentive models with respect to qualifying ACOs.

"(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, 1 or more models if, and to the extent that, such models are beneficial to the program under this title, as determined by the Secretary.

"(B) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall certify that 1 or more of such models described in subparagraph (A) would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

"(i) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—

"(1) EXTENSION.—The Secretary may enter in to an agreement with a qualifying ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary, until the pilot program under this section is operational.

"(2) TRANSITION.—For purposes of extension of an agreement with a qualifying ACO under subsection (g)(2), the Secretary shall treat receipt of an incentive payment for a year by an organization under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such subsection, as long as such practice group practice organization meets the criteria under subsection (b)(2).

"(j) ADDITIONAL PROVISIONS.—

"(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect natural variations in data availability, variation in average annual attributable expenditures, program integrity, and other matters the Secretary deems appropriate.

"(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organizations under the pilot program, the Secretary may limit a qualifying ACO's exposure to high cost patients under the program.

"(3) INVOLVEMENT IN PRIVATE PAYER ARRANGEMENTS.—Nothing in this section shall be construed as preventing qualifying ACOs participating in the pilot program from negotiating similar contracts with private payers.

"(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

"(5) CONSTRUCTION.—Nothing in this section shall be construed to compel or require an organization to use an organization-specific target growth rate for an accountable care organization under this section for purposes of section 1848.

"(6) FUNDING.—For purposes of administering and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c)(1), in addition to funds otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of fiscal years 2010 through 2014 and $20,000,000 for fiscal year 2015. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.".

SEC. 1302. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866E, as inserted by section 1301, the following new section:

"MEDICAL HOME PILOT PROGRAM

"SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

"(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the 'pilot program') for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to high need beneficiaries (as defined in subsection (d)(1)(C)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

"(2) SCOPE.—Subject to subsection (g), the pilot program shall include urban, rural, and underserved areas.

"(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

"(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

"(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

"(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

"(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

"(i) all the requirements of this section are met; and

"(ii) the nurse practitioner is acting consistently with State law.

"(B) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

"(i) all the requirements of this section are met; and

"(ii) the physician assistant is acting consistently with State law.

"(b) DEFINITIONS.—For purposes of this section:

"(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'patient-centered medical home services' means services that—

"(A) provide beneficiaries with direct and ongoing access to a primary care or principal care by a physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

"(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

"(C) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified providers for all stages of life;

"(D) provide continuous access to care and communication with participating beneficiaries;

"(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

"(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

"(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

"(2) PRIMARY CARE.—The term 'primary care' means health care that is provided by a physician, nurse practitioner, or physician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

"(3) PRINCIPAL CARE.—The term 'principal care' means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management.

"(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

"(1) IN GENERAL.—

"(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments

for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3)(B) for a targeted high need beneficiaries (as defined in subparagraph (C)).

"(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term 'independent patient-centered medical home' means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

"(i) providing beneficiaries with patient-centered medical home services; and

"(ii) meets such other requirements as the Secretary may specify.

"(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term 'targeted high need beneficiary' means a high need beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

"(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

"(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 6 months after the date of the enactment of this section.

"(2) STANDARD SETTING AND QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall review alternative models for standard setting and qualification, and shall establish a process—

"(A) to establish standards to enable medical practices to qualify as patient-centered medical homes; and

"(B) to initially provide for the review and certification of medical practices as meeting such standards.

"(3) PAYMENT.—

"(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

"(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

"(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

"(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

"(i) The clinical work and practice expenses involved in providing the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

"(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

"(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

"(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers.

"(5) NO DUPLICATION IN PILOT PARTICIPATION.—A physician in a group practice that participates in the accountable care organization pilot program under section 1866D shall not be eligible to participate in the pilot program under this subsection, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

"(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

"(1) IN GENERAL.—

"(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the 'CBMH

model'), the Secretary shall make payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for high need beneficiaries.

"(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term 'community-based medical home' means a nonprofit community-based or State-based organization that is certified under paragraph (2) as meeting the following requirements:

"(i) The organization provides beneficiaries with medical home services.

"(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary as his or her community-based medical home provider.

"(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

"(iv) The organization meets such other requirements as the Secretary may specify.

"(C) HIGH NEED BENEFICIARY.—In this section, the term 'high need beneficiary' means an individual who requires regular medical monitoring, advising, or treatment.

"(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process—

"(A) for the initial qualification of community-based or State-based organizations as community-based medical homes; and

"(B) to provide for the review and qualification of such community-based and State-based organizations pursuant to criteria established by the Secretary.

"(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under subsection (i).

"(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary may give preference to—

"(A) applications from geographic areas that propose to coordinate health care services for chronically ill beneficiaries across a variety of health care settings, such as primary care physician practices with fewer than 10 physicians, specialty physicians, nurse practitioner practices, Federally qualified health centers, rural health clinics, and other settings;

"(B) applications that include other payors that furnish medical home services for chronically ill patients covered by such payors; and

"(C) applications from States that propose to use the medical home model to coordinate health care services for individuals enrolled under this title, individuals enrolled under title XIX, and full-benefit dual eligible individuals (as defined in section 1935(c)(6)) with chronic diseases across a variety of health care settings.

"(5) PAYMENTS.—

"(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

"(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each high need beneficiary who consents to receive medical home services through such medical home, as follows:

"(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization.

"(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

"(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

"(D) AMOUNT OF PAYMENT.—In determining the amount of such payment, the Secretary shall consider the following:

"(i) The clinical work and practice expenses involved in providing the medical home services provided by the community-based medical home (such as providing increased access, care coordination, care plan setting, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

"(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

"(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a community based or State-based organization or a State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes how such funds will be used.

"(e) EXPANSION OF PROGRAM.—

"(1) EVALUATION OF COST AND QUALITY.—The Secretary shall evaluate the pilot program to determine—

"(A) the extent to which medical homes result in—

"(i) improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;

"(ii) improvement in reducing health disparities;

"(iii) reductions in preventable hospitalizations;

"(iv) prevention of readmissions;

"(v) reductions in emergency room visits;

"(vi) improvement in health outcomes, including patient functional status where applicable;

"(vii) improvement in patient satisfaction;

"(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

"(ix) reductions in health care expenditures; and

"(B) the feasability and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

"(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

"(3) EXPANSION OF PROGRAM.—

"(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

"(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

"(f) ADMINISTRATIVE PROVISIONS.—

"(1) NO DUPLICATION IN PAYMENTS.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

"(2) NO EFFECT ON PAYMENT FOR EVALUATION AND MANAGEMENT SERVICES.—Payments made under this section are in addition to, and have no effect on the amount of, payment for evaluation and management services made under this title

"(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

"(g) FUNDING.—

"(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust

Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

"(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

"(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

"(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

"(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

"(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

"(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount provided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note).

"(2) Notwithstanding section 1302(c) of the America's Affordable Health Choices Act of 2009, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

(c) CONFORMING REPEAL.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note), as amended by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is repealed.

SEC. 1303. PAYMENT INCENTIVE FOR SELECTED PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 1833 of the Social Security Act is amended by inserting after subsection (o) the following new subsection:

"(p) PRIMARY CARE PAYMENT INCENTIVES.—

"(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner (as defined in paragraph (3)) for which amounts are payable under section 1848, in addition to the amount otherwise paid under this part there shall also be paid to the practitioner (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a primary care health professional shortage area.

"(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term 'primary care services'—

"(A) means services which are evaluation and management services as defined in section 1848(j)(5)(A); and

"(B) includes services furnished by another health care professional that would be described in subparagraph (A) if furnished by a physician.

"(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term 'primary care practitioner'—

"(A) means a physician or other health care practitioner (including a nurse practitioner) who—

"(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

"(ii) has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed

charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

"(B) includes a physician assistant who is under the supervision of a physician described in subparagraph (A).

"(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

"(A) any determination or designation under this subsection;

"(B) the identification of services as primary care services under this subsection; and

"(C) the identification of a practitioner as a primary care practitioner under this subsection.

"(5) COORDINATION WITH OTHER PAYMENTS.—

"(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

"(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1834(g)(2)(B).".

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

"(4) The provisions of this subsection shall not be taken into account in applying subsections (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.".

(2) Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting ", (p)," after "(m)".

(3) Section 1848(o)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting "primary care" before "health professional shortage area".

SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking "(but in no event" and all that follows through "performed by a physician)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) MEDICARE COVERED PREVENTIVE SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 1233(a)(1)(B), is amended by adding at the end the following new subsection:

"Medicare Covered Preventive Services

"(iii)(1) Subject to the succeeding provisions of this subsection, the term 'Medicare covered preventive services' means the following:

"(A) Prostate cancer screening tests (as defined in subsection (oo)).

"(B) Colorectal cancer screening tests (as defined in subsection (pp).

"(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

"(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

"(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

"(F) An initial preventive physical examination (as defined in subsection (ww)).

"(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

"(H) Diabetes screening tests (as defined in subsection (yy)).

"(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

"(J) Pneumococcal and influenza vaccines and their administration (as described in subsection (s)(10)(A)) and hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

"(K) Screening mammography (as defined in subsection (jj)).

"(L) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

"(M) Bone mass measurement (as defined in subsection (rr)).

"(N) Kidney disease education services (as defined in subsection (ggg)).

"(O) Additional preventive services (as defined in subsection (ddd)).

"(2) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.".

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) IN GENERAL.—

(A) IN GENERAL.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by adding after and below paragraph (9) the following: "With respect to Medicare covered preventive services, in any case in which the payment rate otherwise provided under this part is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.".

(B) APPLICATION TO SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(i) in paragraph (2)(C), by amending clause (ii) to read as follows:

"(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied."; and

(ii) in paragraph (3)(C), by amending clause (ii) to read as follows:

"(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.".

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking "screening mammography (as defined in section 1861(jj)) and diagnostic mammography" and inserting "diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(iii)(1))".

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking "and" after the semicolon at the end;

(ii) in subparagraph (G), by adding "and" at the end; and

(iii) by adding at the end the following new subparagraph:

"(H) with respect to additional preventive services (as defined in section 1861(ddd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);".

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (1), by striking "items and services described in section 1861(s)(10)(A)" and inserting "Medicare covered preventive services (as defined in section 1861(iii))";

(B) by inserting "and" before "(4)"; and

(C) by striking clauses (5) through (8).

(4) APPLICATION TO PROVIDERS OF SERVICES.—Section 1866(a)(2)(A)(ii) of such Act (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting "other than for Medicare covered preventive services and" after "for such items and services (".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 1305(b), is further amended—

(1) in subsection (a), in the sentence added by section 1305(b)(1)(A), by inserting "(including services described in the last sentence of section 1833(b))" after "preventive services"; and

(2) in subsection (b), by adding at the end the following new sentence: "Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.

SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "clinical social worker services," after "qualified psychologist services,".

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking "and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after July 1, 2010.

SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 1235, is amended—

(A) in subparagraph (EE), by striking "and" at the end;

(B) in subparagraph (FF), by adding "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(GG) marriage and family therapist services (as defined in subsection (jjj));".

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 1233 and 1305, is amended by adding at the end the following new subsection:

"Marriage and Family Therapist Services

"(jjj)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'marriage and family therapist' means an individual who—

"(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

"(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

"(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.".

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services;".

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking "and" before "(W)"; and

(ii) by inserting before the semicolon at the end the following: ", and (X) with respect to marriage and family therapist services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)".

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A HEALTH CARE PROFESSIONAL.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician or nurse practitioner in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section

1307(a), is amended by inserting "marriage and family therapist services (as defined in subsection (jjj)(1))," after "clinical social worker services,".

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (jjj)(2))),".

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

"(vii) A marriage and family therapist (as defined in section 1861(jjj)(2)).".

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as previously amended, is further amended—

(A) in subparagraph (FF), by striking "and" at the end;

(B) in subparagraph (GG), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(HH) mental health counselor services (as defined in subsection (kkk)(1));".

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as previously amended, is amended by adding at the end the following new subsection:

"Mental Health Counselor Services

"(kkk)(1) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.".

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking "and" at the end of clause (iv);

(B) by adding "and" at the end of clause (v); and

(C) by adding at the end the following new clause:

"(vi) mental health counselor services;".

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is further amended—

(i) by striking "and" before "(X)"; and

(ii) by inserting before the semicolon at the end the following: ", and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)".

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 1307(a)

and subsection (a), is amended by inserting "mental health counselor services (as defined in section 1861(kkk)(1))," after "marriage and family therapist services (as defined in subsection (jjj)(1)),".

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a), is amended by striking "or by a marriage and family therapist (as defined in subsection (jjj)(2))," and inserting "by a marriage and family therapist (as defined in subsection (jjj)(2)), or a mental health counselor (as defined in subsection (kkk)(2)),".

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

"(viii) A mental health counselor (as defined in section 1861(kkk)(2)).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking "December 31, 2009" and inserting "December 31, 2011".

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

"(10) federally recommended vaccines (as defined in subsection (lll)) and their respective administration;".

(b) FEDERALLY RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

"Federally Recommended Vaccines

"(lll) The term 'federally recommended vaccine' means an approved vaccine recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).".

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking "1861(s)(10)(A)" and inserting "1861(s)(10)" each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking "subparagraph (A) or (B) of"; and

(B) by inserting before the period the following: "and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011".

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended by striking subparagraph (G) and inserting the following:

"(G) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) for purposes of implementation of this section.".

(4) Section 1860D–2(e)(1) of such Act (42 U.S.C. 1395w–102(e)(1)) is amended by striking "such term includes a vaccine" and all that follows through "its administration) and".

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking "Pneumococcal, influenza, and hepatitis B vaccine and administration" and inserting "Federally recommended vaccines (as defined in subsection (lll)) and their respective administration".

(6) Section 1861(iii)(1) of such Act, as added by section 1305(a), is amended by amending subparagraph (J) to read as follows:

"(J) Federally recommended vaccines (as defined in subsection (lll)) and their respective administration.".

(7) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting "(A)(iv) (including influenza vaccines furnished on or after January 1, 2011)," after "described in subparagraph"

(d) EFFECTIVE DATES.—The amendments made by—

(1) this section (other than by subsection (c)(7)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(7) shall apply to calendar quarters beginning on or after January 1, 2010.

SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

"(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and services described in section 1861(iii); and".

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding at the end the following new part:

"PART D—COMPARATIVE EFFECTIVENESS RESEARCH

"COMPARATIVE EFFECTIVENESS RESEARCH

"SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

"(1) IN GENERAL.—The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

"(2) DUTIES.—The Center shall—

"(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

"(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

"(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

"(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2); and

"(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data.

"(3) POWERS.—

"(A) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Center, the head of that department or agency shall furnish that information to the Center on an agreed upon schedule.

"(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

"(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

"(iii) adopt procedures allowing any interested party to submit information for the use by the Center and Commission under subsection (b) in making reports and recommendations.

"(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

"(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

"(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

"(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to oversee and evaluate the activities carried out by the Center under subsection (a), subject to the authority of the Secretary, to ensure such activities result in highly credible research and information resulting from such research.

"(2) DUTIES.—The Commission shall—

"(A) determine national priorities for research described in subsection (a) and in making such determinations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

"(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

"(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

"(D) review the methodologies developed by the center under subsection (a)(2)(C);

"(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

"(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

"(G) make recommendations for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

"(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall consult with patients and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

"(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

"(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders; and

"(K) make recommendations to the center for the broad dissemination of the findings of research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value.

"(3) COMPOSITION OF COMMISSION.—

"(A) IN GENERAL.—The members of the Commission shall consist of—

"(i) the Director of the Agency for Healthcare Research and Quality;

"(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

"(iii) 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

Of such members, at least 9 shall be practicing physicians, health care practitioners, consumers, or patients.

"(B) QUALIFICATIONS.—

"(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

"(I) Epidemiology.

"(II) Health services research.
"(III) Bioethics.
"(IV) Decision sciences.
"(V) Health disparities.
"(VI) Economics.

"(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

"(I) Patients.
"(II) Health care consumers.
"(III) Practicing Physicians, including surgeons.
"(IV) Other health care practitioners engaged in clinical care.
"(V) Employers.
"(VI) Public payers.
"(VII) Insurance plans.
"(VIII) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

"(C) LIMITATION.—No more than 3 of the Members of the Commission may be representatives of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(VIII).

"(4) APPOINTMENT.—

"(A) IN GENERAL.—The Secretary shall appoint the members of the Commission.

"(B) CONSULTATION.—In considering candidates for appointment to the Commission, the Secretary may consult with the Government Accountability Office and the Institute of Medicine of the National Academy of Sciences.

"(5) CHAIRMAN; VICE CHAIRMAN.—The Secretary shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Secretary may designate another member for the remainder of that member's term. The Chairman shall serve as an ex officio member of the National Advisory Council of the Agency for Health Care Research and Quality under section 931(c)(3)(B) of the Public Health Service Act.

"(6) TERMS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

"(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

"(i) 8 shall be appointed for a term of 4 years; and
"(ii) 7 shall be appointed for a term of 3 years.

"(7) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

"(8) CONFLICTS OF INTEREST.—

"(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(H), the Secretary or the Commission, respectively, shall take into consideration any financial interest (as defined in subparagraph (D)), consistent with this paragraph, and develop a plan for managing any identified conflicts.

"(B) EVALUATION AND CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described paragraph (2)(H) the Secretary or the Commission shall review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(iii) for service on the Commission at a meeting of the Commission.

"(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

"(i) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Commission or a clinical perspective advisory panel described in paragraph (2)(H) regarding a 'particular matter' (as that term is used in section 208 of title 18, United States Code), each member of the Commission or the clinical perspective advisory panel who is a full-time

Government employee or special Government employee shall disclose to the Secretary financial interests in accordance with subsection (b) of such section 208.

"(ii) PROHIBITIONS ON PARTICIPATION.—Except as provided under clause (iii), a member of the Commission or a clinical perspective advisory panel described in paragraph (2)(H) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the Government officers or employees to which such regulations apply.

"(iii) WAIVER.—If the Secretary determines it necessary to afford the Commission or a clinical perspective advisory panel described in paragraph 2(H) essential expertise, the Secretary may grant a waiver of the prohibition in clause (ii) to permit a member described in such subparagraph to—

"(I) participate as a non-voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting; or

"(II) participate as a voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting.

"(iv) LIMITATION ON WAIVERS AND OTHER EXCEPTIONS.—

"(I) DETERMINATION OF ALLOWABLE EXCEPTIONS FOR THE COMMISSION.—The number of waivers granted to members of the Commission cannot exceed one-half of the total number of members for the Commission.

"(II) PROHIBITION ON VOTING STATUS ON CLINICAL PERSPECTIVE ADVISORY PANELS.—No voting member of any clinical perspective advisory panel shall be in receipt of a waiver. No more than two nonvoting members of any clinical perspective advisory panel shall receive a waiver.

"(D) FINANCIAL INTEREST DEFINED.—For purposes of this paragraph, the term 'financial interest' means a financial interest under section 208(a) of title 18, United States Code.

"(9) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

"(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Commission, the Commission may—

"(A) appoint an Executive Director (subject to the approval of the Secretary) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(D) make advance, progress, and other payments which relate to the work of the Commission;

"(E) provide transportation and subsistence for persons serving without compensation; and

"(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

"(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

"(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

"(B) Methods of conducting such research shall be scientifically based.

"(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

"(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

"(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

"(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall consider advice given to the Center by the clinical perspective advisory panel for the national research priority.

"(3) STAKEHOLDER INPUT.—

"(A) IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission.

"(B) SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—

"(i) recommending research priorities and questions;

"(ii) recommending research methodologies; and

"(iii) advising on and assisting with efforts to disseminate research findings.

"(C) OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—

"(i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center; and

"(ii) ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Commission.

"(4) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

"(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items and services used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), and individuals with different comorbidities; and—

"(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

"(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

"(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

"(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by the Center or a grantee or contractor of the Center:

"(A) Any interim or progress reports as deemed appropriate by the Secretary.

"(B) Stakeholder comments.

"(C) A final report.

"(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

"(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

"(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions;

"(B) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate;

"(C) include considerations such as limitations of research and what further research may be needed, as appropriate;

"(D) not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and

"(E) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

"(2) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Center shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting such protocols and strategies, the Center shall consult with stakeholders concerning the types of dissemination that will be most useful to the end users of information and may provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.

"(f) REPORTS TO CONGRESS.—

"(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section. Each such report shall include a discussion of the Center's compliance with subsection (c)(4)(B), including any reasons for lack of compliance with such subsection.

"(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

"(3) ANALYSIS AND REVIEW.—Not later than December 31, 2013, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Commission but not funded.

"(g) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available, without the need for further appropriations and without fiscal year limitation, to the Secretary to carry out this section.

"(h) CONSTRUCTION.—Nothing in this section shall be construed to permit the Commission or the Center to mandate coverage, reimbursement, or other policies for any public or private payer.".

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR THE TRUST FUND.—For provision establishing a Comparative Effectiveness Research Trust Fund and financing such Trust Fund, see section 1802.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES AND NURSING FACILITIES

SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

"(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

"(1) DISCLOSURE.—A facility (as defined in paragraph (7)(B)) shall have the information described in paragraph (3) available—

"(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 1411(b) of the America's Affordable Health Choices Act of 2009, for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is

located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (4)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

"(2) PUBLIC AVAILABILITY OF INFORMATION.—During the period described in paragraph (1)(A), a facility shall—

"(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

"(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

"(3) INFORMATION DESCRIBED.—

"(A) IN GENERAL.—The following information is described in this paragraph:

"(i) The information described in subsections (a) and (b), subject to subparagraph (C).

"(ii) The identity of and information on—

"(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

"(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

"(III) each person or entity who is an additional disclosable party of the facility.

"(iii) The organizational structure of each person and entity described in subclauses (II) and (III) of clause (ii) and a description of the relationship of each such person or entity to the facility and to one another.

"(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such Form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

"(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

"(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

"(4) REPORTING.—

"(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (3) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is accurate and current.

"(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

"(5) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

"(6) DEFINITIONS.—In this subsection:

"(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

"(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

"(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property;

"(iii) lends funds or provides a financial guarantee to the facility in an amount which is equal to or exceeds $50,000; or

"(iv) provides management or administrative services, clinical consulting services, or accounting or financial services to the facility.

"(B) FACILITY.—The term 'facility' means a disclosing entity which is—

"(i) a skilled nursing facility (as defined in section 1819(a)); or

"(ii) a nursing facility (as defined in section 1919(a)).

"(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

"(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

"(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

"(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

"(iii) a general partnership, the partners of the general partnership;

"(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

"(v) a trust, the trustees of the trust;

"(vi) an individual, contact information for the individual; and

"(vii) any other person or entity, such information as the Secretary determines appropriate.".

(b) PUBLIC AVAILABILITY OF INFORMATION.—

(1) IN GENERAL.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(4)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the information reported in accordance with such final regulations shall be made available to the public in accordance with procedures established by the Secretary.

(2) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(c) CONFORMING AMENDMENTS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

SEC. 1412. ACCOUNTABILITY REQUIREMENTS.

(a) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 1411(c)(1), is amended by adding at the end the following new subparagraph:

"(C) COMPLIANCE AND ETHICS PROGRAMS.—

"(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a skilled nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

"(ii) DEVELOPMENT OF REGULATIONS.—

"(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

"(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multi-unit nursing home chains.

"(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

"(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a skilled nursing facility, a program of the operating organization that—

"(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

"(II) includes at least the required components specified in clause (iv).

"(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

"(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

"(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

"(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

"(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

"(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a report-

ing system whereby employees and other agents could report violations by others within the organization without fear of retribution.

"(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

"(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

"(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

"(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a skilled nursing facility in lieu of section 1874(d).".

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

"(C) COMPLIANCE AND ETHICS PROGRAM.—

"(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

"(ii) DEVELOPMENT OF REGULATIONS.—

"(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall develop regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

"(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi-unit nursing home chains.

"(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

"(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a nursing facility, a program of the operating organization that—

"(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

"(II) includes at least the required components specified in clause (iv).

"(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

"(I) The organization must have established compliance standards and procedures to be followed by its employees and other

agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

"(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and has sufficient resources and authority to assure such compliance.

"(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

"(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

"(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

"(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

"(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

"(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

"(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(77).".

(b) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(1) SKILLED NURSING FACILITIES.—Section 1819(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking "ASSURANCE" and inserting "ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM";

(B) by designating the matter beginning with "A skilled nursing facility" as a clause (i) with the heading "IN GENERAL.—" and the appropriate indentation;

(C) in clause (i) (as so designated by subparagraph (B)), by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively; and

(D) by adding at the end the following new clause:

"(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

"(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for skilled nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a skilled nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

"(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.".

(2) NURSING FACILITIES.—Section 1919(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r(b)(1)(B)) is amended—

(A) by striking "ASSURANCE" and inserting "ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM";

(B) by designating the matter beginning with "A nursing facility" as a clause (i) with the heading "IN GENERAL.—" and the appropriate indentation; and

(C) by adding at the end the following new clause:

"(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

"(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the 'QAPI program') for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

"(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.".

(3) PROPOSAL TO REVISE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—The Secretary shall include in the proposed rule published under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(A)) for the subsequent fiscal year to the extent otherwise authorized under section 1819(b)(1)(B) or 1819(d)(1)(C) of the Social Security Act or other statutory or regulatory authority, one or more proposals for skilled nursing facilities to modify and strengthen quality assurance and performance improvement programs in such facilities. At the time of publication of such proposed rule and to the extent otherwise authorized under section 1919(b)(1)(B) or 1919(d)(1)(C) of such Act or other regulatory authority.

(4) FACILITY PLAN.—Not later than 1 year after the date on which the regulations are promulgated under subclause (II) of clause (ii) of sections 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Security Act, as added by paragraphs (1) and (2), a skilled nursing facility and a nursing facility must submit to the Secretary a plan for the facility to meet the standards under such regulations and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i) of such sections.

(c) GAO STUDY ON NURSING FACILITY UNDERCAPITALIZATION.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that examines the following:

(A) The extent to which corporations that own or operate large numbers of nursing facilities, taking into account ownership type (including private equity and control interests), are undercapitalizing such facilities.

(B) The effects of such undercapitalization on quality of care, including staffing and food costs, at such facilities.

(C) Options to address such undercapitalization, such as requirements relating to surety bonds, liability insurance, or minimum capitalization.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) NURSING FACILITY.—In this subsection, the term "nursing facility" includes a skilled nursing facility.

SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(i) NURSING HOME COMPARE WEBSITE.—

"(1) INCLUSION OF ADDITIONAL INFORMATION.—

"(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the

'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

"(i) Information that is reported to the Secretary under section 1124(c)(4).

"(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare and Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

"(I) were newly enrolled in the program;

"(II) are enrolled in the program and have failed to significantly improve;

"(III) are enrolled in the program and have significantly improved;

"(IV) have graduated from the program; and

"(V) have closed voluntarily or no longer participate under this title.

"(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

"(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

"(II) differences in types of staff (such as training associated with different categories of staff);

"(III) the relationship between nurse staffing levels and quality of care; and

"(IV) an explanation that appropriate staffing levels vary based on patient case mix.

"(iv) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

"(v) The standardized complaint form developed under subsection (f)(8), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

"(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

"(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

"(I) that were committed inside the facility;

"(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

"(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

"(B) DEADLINE FOR PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

"(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

"(2) REVIEW AND MODIFICATION OF WEBSITE.—

"(A) IN GENERAL.—The Secretary shall establish a process—

"(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

"(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

"(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

"(i) State long-term care ombudsman programs;

"(ii) consumer advocacy groups;

"(iii) provider stakeholder groups; and

"(iv) any other representatives of programs or groups the Secretary determines appropriate.".

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.".

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

"(8) SPECIAL FOCUS FACILITY PROGRAM.—

"(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

"(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.".

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(i) NURSING HOME COMPARE WEBSITE.—

"(1) INCLUSION OF ADDITIONAL INFORMATION.—

"(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

"(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C)(ii), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

"(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

"(II) differences in types of staff (such as training associated with different categories of staff);

"(III) the relationship between nurse staffing levels and quality of care; and

"(IV) an explanation that appropriate staffing levels vary based on patient case mix.

"(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

"(iii) The standardized complaint form developed under subsection (f)(10), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

"(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

"(v) The number of adjudicated instances of criminal violations by employees of a nursing facility—

"(I) that were committed inside of the facility; and

"(II) with respect to such instances of violations or crimes committed outside of the facility, that were the violations or crimes that resulted in the serious bodily injury of an elder.

"(B) DEADLINE FOR PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

"(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

"(2) REVIEW AND MODIFICATION OF WEBSITE.—

"(A) IN GENERAL.—The Secretary shall establish a process—

"(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

"(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

"(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

"(i) State long-term care ombudsman programs;

"(ii) consumer advocacy groups;

"(iii) provider stakeholder groups;

"(iv) skilled nursing facility employees and their representatives; and

"(v) any other representatives of programs or groups the Secretary determines appropriate.".

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.".

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of such Act is amended by adding at the end of the following new paragraph:

"(10) SPECIAL FOCUS FACILITY PROGRAM.—

"(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Sec-

retary has identified as having substantially failed to meet applicable requirements of this Act.

"(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.".

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

"(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

"(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

"(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.".

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

"(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

"(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

"(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking "and" at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;".

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

"(f) REPORTING OF DIRECT CARE EXPENDITURES.—

"(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 3 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

"(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

"(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

"(A) Spending on direct care services (including nursing, therapy, and medical services).

"(B) Spending on indirect care (including housekeeping and dietary services).

"(C) Capital assets (including building and land costs).

"(D) Administrative services costs.

"(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.".

SEC. 1415. STANDARDIZED COMPLAINT FORM.

(a) SKILLED NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(a)(3), is amended by adding at the end the following new paragraph:

"(9) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a skilled nursing facility.".

(2) STATE REQUIREMENTS.—Section 1819(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

"(6) COMPLAINT PROCESSES AND WHISTLE-BLOWER PROTECTION.—

"(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(9) available upon request to—

"(i) a resident of a skilled nursing facility;

"(ii) any person acting on the resident's behalf; and

"(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

"(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the skilled nursing facility, that the legal representative of a resident of a skilled nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or work-

er used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

"(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

"(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

"(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

"(iv) procedures to ensure that the identity of the complainant will be kept confidential.

"(C) WHISTLEBLOWER PROTECTION.—

"(i) PROHIBITION AGAINST RETALIATION.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

"(ii) RETALIATORY REPORTING.—A skilled nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

"(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated , or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and such other relief as the court deems just and proper.

"(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

"(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

"(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(9) (including submitting a complaint orally).

"(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

"(i) the information reported or disclosed in the complaint is true; and

"(ii) the violation of this title has occurred or may occur in relation to such information.".

(b) NURSING FACILITIES.—

(1) DEVELOPMENT BY THE SECRETARY.—Section 1919(f) of the Social Security Act (42 U.S.C. 1395i–3(f)), as amended by section 1413(b), is amended by adding at the end the following new paragraph:

"(11) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.".

(2) STATE REQUIREMENTS.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

"(8) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

"(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

"(i) a resident of a nursing facility;

"(ii) any person acting on the resident's behalf; and

"(iii) any person who works at a nursing facility or a representative of such a worker.

"(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a resident of a nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(11) or some other method for submitting the complaint. Such complaint resolution process shall include—

"(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

"(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

"(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

"(iv) procedures to ensure that the identity of the complainant will be kept confidential.

"(C) WHISTLEBLOWER PROTECTION.—

"(i) PROHIBITION AGAINST RETALIATION.—No person who works at a nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(11) or some other method for submitting the complaint.

"(ii) RETALIATORY REPORTING.—A nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

"(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated, or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and such other relief as the court deems just and proper.

"(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

"(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

"(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(11) (including submitting a complaint orally).

"(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

"(i) the information reported or disclosed in the complaint is true; and

"(ii) the violation of this title has occurred or may occur in relation to such information.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.

(a) SKILLED NURSING FACILITIES.—Section 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8)) is amended by adding at the end the following new subparagraph:

"(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a skilled nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

"(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

"(ii) include resident census data and information on resident case mix;

"(iii) include a regular reporting schedule; and

"(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.".

(b) NURSING FACILITIES.—Section 1919(b)(8) of the Social Security Act (42 U.S.C. 1396r(b)(8)) is amended by adding at the end the following new subparagraph:

"(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according

to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

"(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

"(ii) include resident census data and information on resident case mix;

"(iii) include a regular reporting schedule; and

"(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.".

PART 2—TARGETING ENFORCEMENT

SEC. 1421. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended to read as follows:

"(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

"(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

"(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term 'applicable per instance amount' means—

"(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

"(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

"(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

"(III) APPLICABLE PER DAY AMOUNT.—In this clause, the term 'applicable per day amount' means—

"(aa) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

"(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

"(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

"(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in subclause (II)(bb).

"(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 per-

cent on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

"(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

"(aa) subject to item (cc), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

"(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

"(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

"(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting "(ii),"after "(i),".

(b) NURSING FACILITIES.—

(1) PENALTIES IMPOSED BY THE STATE.—

(A) IN GENERAL.—Section 1919(h)(2) of the Social Security Act (42 U.S.C. 1396r(h)(2)) is amended—

(i) in subparagraph (A)(ii), by striking the first sentence and inserting the following: "A civil money penalty in accordance with subparagraph (G).."; and

(ii) by adding at the end the following new subparagraph:

"(G) CIVIL MONEY PENALTIES.—

"(i) IN GENERAL.—The State may impose a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

"(ii) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term 'applicable per instance amount' means—

"(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

"(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

"(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

"(iii) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term 'applicable per day amount' means—

"(I) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

"(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

"(iv) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

"(v) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

"(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(II) or (iii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

"(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (iv) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

"(vi) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

"(I) subject to subclause (III), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

"(II) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under subclause (I) is completed;

"(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subclause (I) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(V) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(VI) in the case where all such appeals are unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).".

(B) CONFORMING AMENDMENT.—The second sentence of section 1919(h)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(2)(A)(ii)) is amended by inserting before the period at the end the following: ", and some portion of such funds may be used to support activities that benefit

residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, providing technical assistance to facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary)".

(2) PENALTIES IMPOSED BY THE SECRETARY.—

(A) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended to read as follows:

"(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

"(I) AMOUNT.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

"(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

"(III) PROHIBITION ON REDUCTION FOR REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

"(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

"(aa) subject to item (bb), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

"(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

"(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

"(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

"(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

"(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

"(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money pen-

alty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) CONFORMING AMENDMENT.—Section 1919(h)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting "and in paragraph (3)(C)(ii)" after "paragraph (2)(A)".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the "pilot program") to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program based on criteria selected by the Secretary, including where evidence suggests that one or more facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes one or more facilities participating in the "Special Focus Facility" program (or a successor program) or one or more facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES OF THE INDEPENDENT MONITOR.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of such program shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of the chain and the principal business partners of such owners in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after the date of receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State (or States) involved, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the pilot program. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the pilot program.

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

(h) DEFINITIONS.—In this section:

(1) FACILITY.—The term "facility" means a skilled nursing facility or a nursing facility.

(2) NURSING FACILITY.—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program. Such evaluation shall—

(A) determine whether the independent monitor program should be established on a permanent basis; and

(B) if the Inspector General determines that the independent monitor program should be established on a permanent basis, recommend appropriate procedures and mechanisms for such establishment.

(2) REPORT.—Not later than 180 days after the completion of the pilot program, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended by adding at the end the following new paragraph:

"(7) NOTIFICATION OF FACILITY CLOSURE.—

"(A) IN GENERAL.—Any individual who is the administrator of a skilled nursing facility must—

"(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

"(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

"(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

"(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

"(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

"(B) RELOCATION.—

"(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

"(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.".

(2) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(A) in the first sentence, by striking "the Secretary shall terminate" and inserting "the Secretary, subject to subsection (c)(7), shall terminate"; and

(B) in the second sentence, by striking "subsection (c)(2)" and inserting "paragraphs (2) and (7) of subsection (c)".

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1396r(c)) is amended by adding at the end the following new paragraph:

"(9) NOTIFICATION OF FACILITY CLOSURE.—

"(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

"(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

"(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

"(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

"(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

"(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

"(B) RELOCATION.—

"(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

"(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)" after "curriculum".

(b) NURSING FACILITIES.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)" after "curriculum".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISORY STAFF.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities. The study shall include an analysis of the following:

(A) Whether the number of initial training hours for certified nurse aides required under sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(II); 1396r(f)(2)(A)(i)(II)) should be increased from 75 and, if so, what the required number of initial training hours should be, including any recommendations for the content of such training (including training related to dementia).

(B) Whether requirements for ongoing training under such sections 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II) should be increased from 12 hours per year, including any recommendations for the content of such training.

(2) CONSULTATION.—In conducting the analysis under paragraph (1)(A), the Secretary shall consult with States that, as of the date of the enactment of this Act, require more than 75 hours of training for certified nurse aides.

(3) DEFINITIONS.—In this section:

(A) NURSING FACILITY.—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(C) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

"PART E—QUALITY IMPROVEMENT

"ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

"SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

"(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

"(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

"(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic diseases;

"(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

"(3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care, including those due to variations in care;

"(4) address health disparities across groups and areas; and

"(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

"(d) DEFINITIONS.—In this part:

"(1) CONSENSUS-BASED ENTITY.—The term 'consensus-based entity' means an entity with a contract with the Secretary under section 1890.

"(2) QUALITY MEASURE.—The term 'quality measure' means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

"(e) FUNDING.—

"(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

"(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.".

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

Part E of title XI of the Social Security Act, as added by section 1441, is amended by adding at the end the following new sections:

"SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.

"(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

"(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

"(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

"(3) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

"(A) seek public input; and

"(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

"(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

"(c) DEVELOPMENT OF QUALITY MEASURES.—

"(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—Quality measures developed under agreements under subsection (a) shall be designed—

"(A) to assess outcomes and functional status of patients;

"(B) to assess the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

"(C) to assess patient experience and patient engagement;

"(D) to assess the safety, effectiveness, and timeliness of care;

"(E) to assess health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language;

"(F) to assess the efficiency and resource use in the provision of care;

"(G) to the extent feasible, to be collected as part of health information technologies supporting better delivery of health care services;

"(H) to be available free of charge to users for the use of such measures; and

"(I) to assess delivery of health care services to individuals regardless of age.

"(2) AVAILABILITY OF MEASURES.—The Secretary shall make quality measures developed under this section available to the public.

"(3) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.

"(4) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the updating (and testing, if applicable) by consensus-based entities of quality measures that have been previously endorsed by such an entity as new evidence is developed, in a manner consistent with section 1890(b)(3).

"(d) QUALIFIED ENTITIES.—Before entering into agreements with a qualified entity, the Secretary shall ensure that the entity is a public, nonprofit or academic institution with technical expertise in the area of health quality measurement.

"(e) APPLICATION FOR GRANT.—A grant may be made under this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(f) FUNDING.—

"(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $25,000,000, to the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.

"(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $25,000,000 for each of the fiscal years 2010 through 2014.

"SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

"(a) GAO EVALUATIONS.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

"(b) CONSIDERATIONS.—In carrying out the evaluation under subsection (a), the Comptroller General shall determine—

"(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;

"(2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients' personal health information and provides data security;

"(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and

"(4) the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.

"(c) REPORT.—The Comptroller General shall submit reports to Congress and to the Secretary containing a description of the findings and conclusions of the results of each such evaluation.".

SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

"(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.—

"(1) LIST OF MEASURES.—Not later than December 1 before each year (beginning with 2011), the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the calendar year following such year, as the case may be.

"(2) CONSULTATION ON SELECTION OF ENDORSED QUALITY MEASURES.—A consensus-based entity that has entered into a contract under section 1890 shall, as part of such contract, convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in public health care programs.

"(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.

"(4) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

"(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (2) with respect to the selection of quality measures, the consensus-based entity described in such paragraph shall provide for an open and transparent process for the activities conducted pursuant to such convening.

"(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under paragraph (2) shall ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection.

"(5) USE OF INPUT.—The respective proposed rule shall contain a summary of the recommendations made by the multi-stakeholder groups under paragraph (2), as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

"(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

"(A) Hospitals and other institutional providers.

"(B) Physicians.

"(C) Health care quality alliances.

"(D) Nurses and other health care practitioners.

"(E) Health plans.

"(F) Patient advocates and consumer groups.

"(G) Employers.

"(H) Public and private purchasers of health care items and services.
"(I) Labor organizations.
"(J) Relevant departments or agencies of the United States.
"(K) Biopharmaceutical companies and manufacturers of medical devices.
"(L) Licensing, credentialing, and accrediting bodies.

"(7) FUNDING.—

"(A) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.

"(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this subsection, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.".

SEC. 1444. APPLICATION OF QUALITY MEASURES.

(a) INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

"(x)(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, the quality measures specified under clause (viii) shall be measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

"(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.".

(b) OUTPATIENT HOSPITAL SERVICES.—Section 1833(t)(17) of such Act (42 U.S.C. 1395l(t)(17)) is amended by adding at the end the following new subparagraph:

"(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1886(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to quality measures for inpatient hospital services.".

(c) PHYSICIANS' SERVICES.—Section 1848(k)(2)(C)(ii) of such Act (42 U.S.C. 1395w-4(k)(2)(C)(ii)) is amended by adding at the end the following: "The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.".

(d) RENAL DIALYSIS SERVICES.—Section 1881(h)(2)(B)(ii) of such Act (42 U.S.C. 1395rr(h)(2)(B)(ii)) is amended by adding at the end the following: "The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.".

(e) ENDORSEMENT OF STANDARDS.—Section 1890(b)(2) of the Social Security Act (42 U.S.C. 1395aaa(b)(2)) is amended by adding after and below subparagraph (B) the following:

"If the entity does not endorse a measure, such entity shall explain the reasons and provide suggestions about changes to such measure that might make it a potentially endorsable measure.".

(f) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.

SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by striking "for each of fiscal years 2009 through 2012" and inserting "for fiscal year 2009, and $12,000,000 for each of the fiscal years 2010 through 2012"

Subtitle D—Physician Payments Sunshine Provision

SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BETWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND PHYSICIANS AND OTHER HEALTH CARE ENTITIES AND BETWEEN PHYSICIANS AND OTHER HEALTH CARE ENTITIES.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 1631(a), is further amended by inserting after section 1128G the following new section:

"SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS' FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND WITH ENTITIES THAT BILL FOR SERVICES UNDER MEDICARE.

"(a) REPORTING OF PAYMENTS OR OTHER TRANSFERS OF VALUE.—

"(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011 and annually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

"(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier.

"(B) With respect to the payment or other transfer of value, other than a drug sample—

"(i) its value and date;

"(ii) the name of the related drug, device, or supply, if available; and

"(iii) a description of its form, indicated (as appropriate for all that apply) as—

"(I) cash or a cash equivalent;

"(II) in-kind items or services;

"(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

"(IV) any other form (as defined by the Secretary).

"(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

"(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

"(3) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

"(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENTS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor pursuant to a product development agreement for services furnished in connection with the development of a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

"(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

"(B) Two calendar years after the date such payment or other transfer of value was made.

"(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report as required under

this section in the next reporting period under this subsection after the earlier of the following:

"(A) The date that the clinical investigation is registered on the website maintained by the National Institutes of Health pursuant to section 671 of the Food and Drug Administration Amendments Act of 2007.

"(B) Two calendar years after the date such payment or other transfer of value was made.

"(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until or after the date on which the information is made available to the public under such paragraph.

"(b) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS IN HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization) that bills the Secretary under part A or part B of title XVIII for services shall report on the ownership shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity. In this subsection, the term 'physician' includes a physician's immediate family members (as defined for purposes of section 1877(a)).

"(c) PUBLIC AVAILABILITY.—

"(1) IN GENERAL.—The Secretary shall establish procedures to ensure that, not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under subsections (a) and (b), other than information regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

"(A) is searchable and is in a format that is clear and understandable;

"(B) contains information that is presented by the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

"(C) contains information that is able to be easily aggregated and downloaded;

"(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year;

"(E) contains background information on industry-physician relationships;

"(F) in the case of information submitted with respect to a payment or other transfer of value described in subsection (a)(5), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

"(G) contains any other information the Secretary determines would be helpful to the average consumer; and

"(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

"(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the applicable manufacturer or distributor of a covered drug, device, biological, or medical supply reporting under subsection (a) or hospital or other health care entity reporting physician ownership under subsection (b). The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the manufacturer, distributor, hospital, or other entity reporting under subsection (a) or (b) with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

"(3) SPECIAL RULE FOR DRUG SAMPLES.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

"(4) SPECIAL RULE FOR NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

"(d) PENALTIES FOR NONCOMPLIANCE.—

"(1) FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any applicable manufacturer or distributor that fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection, and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations promulgated to carry out such subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or distributor or other entity shall not exceed $150,000.

"(2) KNOWING FAILURE TO REPORT.—

"(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or distributor that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

"(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) or (b) by an applicable manufacturer, distributor, or entity shall not exceed $1,000,000, or, if greater, 0.1 percentage of the total annual revenues of the manufacturer, distributor, or entity.

"(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

"(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary of an intent to proceed under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against a manufacturer or distributor in the State.

"(e) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

"(1) The information submitted under this section during the preceding year, aggregated for each applicable manufacturer or distributor of a covered drug, device, biological, or medical supply that submitted such information during such year.

"(2) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

"(f) DEFINITIONS.—In this section:

"(1) APPLICABLE MANUFACTURER; APPLICABLE DISTRIBUTOR.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply, and the term 'applicable distributor' means a distributor of a covered drug, device, or medical supply.

"(2) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

"(3) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered' means, with respect to a drug, device, biological, or medical supply, such a drug, device, biological, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

"(4) COVERED RECIPIENT.—The term 'covered recipient' means the following:

"(A) A physician.

"(B) A physician group practice.

"(C) Any other prescriber of a covered drug, device, biological, or medical supply.

"(D) A pharmacy or pharmacist.

"(E) A health insurance issuer, group health plan, or other entity offering a health benefits plan, including any employee of such an issuer, plan, or entity.

"(F) A pharmacy benefit manager, including any employee of such a manager.

"(G) A hospital.

"(H) A medical school.

"(I) A sponsor of a continuing medical education program.

"(J) A patient advocacy or disease specific group.

"(K) A organization of health care professionals.

"(L) A biomedical researcher.

"(M) A group purchasing organization.

"(5) DISTRIBUTOR OF A COVERED DRUG, DEVICE, OR MEDICAL SUPPLY.—The term 'distributor of a covered drug, device, or medical supply' means any entity which is engaged in the marketing or distribution of a covered drug, device, or medical supply (or any subsidiary of or entity affiliated with such entity), but does not include a wholesale pharmaceutical distributor.

"(6) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

"(7) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

"(8) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply (or any subsidiary of or entity affiliated with such entity).

"(9) PAYMENT OR OTHER TRANSFER OF VALUE.—

"(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value for or of any of the following:

"(i) Gift, food, or entertainment.

"(ii) Travel or trip.

"(iii) Honoraria.

"(iv) Research funding or grant.

"(v) Education or conference funding.

"(vi) Consulting fees.

"(vii) Ownership or investment interest and royalties or license fee.

"(B) INCLUSIONS.—Subject to subparagraph (C), the term 'payment or other transfer of value' includes any compensation, gift, honorarium, speaking fee, consulting fee, travel, services, dividend, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

"(C) EXCLUSIONS.—The term 'payment or other transfer of value' does not include the following:

"(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed $5.

"(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

"(iii) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

"(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

"(v) In-kind items used for the provision of charity care.

"(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

"(vii) Compensation paid by a manufacturer or distributor of a covered drug, device, biological, or medical supply to a covered recipient who is directly employed by and works solely for such manufacturer or distributor.

"(viii) Any discount or cash rebate.

"(10) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

"(g) ANNUAL REPORTS TO STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to States a report that includes a summary of the information submitted under subsections (a) and (d) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

"(h) RELATION TO STATE LAWS.—

"(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

"(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any law or regulation of a State or of a political subdivision of a State that requires any of the following:

"(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

"(B) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

"(C) The discovery or admissibility of information described in this section in a criminal, civil, or administrative proceeding.".

(b) AVAILABILITY OF INFORMATION FROM THE DISCLOSURE OF FINANCIAL RELATIONSHIP REPORT (DFRR).—The Secretary of Health and Human Services shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required pursuant to section 5006 of the Deficit Reduction Act of 2005. Such report shall be submitted to Congress not later than the date that is 6 months after the date such surveys are collected and shall be made publicly available on an Internet website of the Department of Health and Human Services.

Subtitle E—Public Reporting on Health Care-Associated Infections

SEC. 1461. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1138 the following section:

"SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

"(a) REPORTING REQUIREMENT.—

"(1) IN GENERAL.—The Secretary shall provide that a hospital (as defined in subsection (g)) or ambulatory surgical center meeting the requirements of titles XVIII or XIX may participate in the programs established under such titles (pursuant to the applicable provisions of law, including sections 1866(a)(1) and 1832(a)(1)(F)(i)) only if, in accordance with this section, the hospital or center reports such information on health care-associated infections that develop in the hospital or center (and such demographic information associated with such infections) as the Secretary specifies.

"(2) REPORTING PROTOCOLS.— Such information shall be reported in accordance with reporting protocols established by the Secretary through the Director

of the Centers for Disease Control and Prevention (in this section referred to as the 'CDC') and to the National Healthcare Safety Network of the CDC or under such another reporting system of such Centers as determined appropriate by the Secretary in consultation with such Director.

"(3) COORDINATION WITH HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is coordinated with systems established under the HITECH Act, where appropriate.

"(4) PROCEDURES TO ENSURE THE VALIDITY OF INFORMATION.—The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall address failures to report as well as errors in reporting.

"(5) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of CDC, shall promulgate regulations to carry out this section.

"(b) PUBLIC POSTING OF INFORMATION.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

"(1) among hospitals and ambulatory surgical centers; and

"(2) by demographic information.

"(c) ANNUAL REPORT TO CONGRESS.—On an annual basis the Secretary shall submit to the Congress a report that summarizes each of the following:

"(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year.

"(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

"(3) Based on the most recent information available to the Secretary on the composition of the professional staff of hospitals and ambulatory surgical centers, the number of certified infection control professionals on the staff of hospitals and ambulatory surgical centers.

"(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

"(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

"(d) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information on health care-associated infections or patient safety procedures for a hospital or ambulatory surgical center.

"(e) HEALTH CARE-ASSOCIATED INFECTION.—For purposes of this section:

"(1) IN GENERAL.—The term 'health care-associated infection' means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

"(2) RELATED TO RECEIVING HEALTH CARE.—The term 'related to receiving health care', with respect to an infection, means that the infection was not incubating or present at the time health care was provided.

"(f) APPLICATION TO CRITICAL ACCESS HOSPITALS.—For purposes of this section, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).".

(b) EFFECTIVE DATE.—With respect to section 1138A of the Social Security Act (as inserted by subsection (a) of this section), the requirement under such section that hospitals and ambulatory surgical centers submit reports takes effect on such date (not later than 2 years after the date of the enactment of this Act) as the Secretary of Health and Human Services shall specify. In order to meet such deadline, the Secretary may implement such section through guidance or other instructions.

(c) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the program established under section 1138A of the Social Security Act, as inserted by subsection (a). Such report shall include an analysis of the appropriateness of the types of information required for submission, compliance with reporting requirements, the success of the validity procedures established, and any conflict or overlap between the reporting required under such section and any other reporting systems mandated by either the States or the Federal Government.

(d) REPORT ON ADDITIONAL DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report on the appropriateness of expanding the requirements under such section to include additional information (such as health care worker immunization rates), in order to improve health care quality and patient safety.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)";

(2) in paragraph (4)(H)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)";

(3) in paragraph (7)(E), by inserting "and paragraph (8)" after "this paragraph"; and

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

"(8) ADDITIONAL REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

"(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

"(i) PROGRAMS SUBJECT TO REDUCTION.—If a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

"(ii) REFERENCE RESIDENT LEVEL.—

"(I) IN GENERAL.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

"(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing residency training program that is not reflected on the most recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident level that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

"(III) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause is the limitation applicable under subclause (I) of such paragraph.

"(IV) PREVIOUS REDISTRIBUTION.—The reference resident level specified in this clause for a hospital shall be increased to the extent required to take into account an increase in resident positions made available to the hospital under paragraph (7)(B) that are not otherwise taken into account under a previous subclause.

"(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and to the extent the hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of available slots accordingly, or which the Secretary otherwise has permitted the resident positions (under section 402 of the Social Security Amendments of 1967) to be

aggregated for purposes of applying the resident position limitations under this subsection.

"(B) REDISTRIBUTION.—

"(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The estimated aggregate number of increases in the otherwise applicable resident limit under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

"(ii) REQUIREMENTS FOR QUALIFYING HOSPITALS.—A hospital is not a qualifying hospital for purposes of this paragraph unless the following requirements are met:

"(I) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—The hospital maintains the number of primary care residents at a level that is not less than the base level of primary care residents increased by the number of additional primary care resident positions provided to the hospital under this subparagraph. For purposes of this subparagraph, the 'base level of primary care residents' for a hospital is the level of such residents as of a base period (specified by the Secretary), determined without regard to whether such positions were in excess of the otherwise applicable resident limit for such period but taking into account the application of subclauses (II) and (III) of subparagraph (A)(ii).

"(II) DEDICATED ASSIGNMENT OF ADDITIONAL RESIDENT POSITIONS TO PRIMARY CARE.—The hospital assigns all such additional resident positions for primary care residents.

"(III) ACCREDITATION.—The hospital's residency programs in primary care are fully accredited or, in the case of a residency training program not in operation as of the base year, the hospital is actively applying for such accreditation for the program for such additional resident positions (as determined by the Secretary).

"(iii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011, made available under this subparagraph, as determined by the Secretary.

"(iv) PRIORITY FOR CERTAIN HOSPITALS.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall distribute the increase to qualifying hospitals based on the following criteria:

"(I) The Secretary shall give preference to hospitals that had a reduction in resident training positions under subparagraph (A).

"(II) The Secretary shall give preference to hospitals with 3-year primary care residency training programs, such as family practice and general internal medicine.

"(III) The Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

"(IV) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

"(V) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (designated under section 332 of the Public Health Service Act) or a health professional needs area (designated under section 2211 of such Act).

"(VI) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

"(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

"(vi) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

"(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph not later than July 1, 2011.

"(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

"(i) The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

"(ii) The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

"(D) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subparagraph (B)—

"(i) to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs; and

"(ii) as a condition of payment for a cost reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

"(I) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(I)) before receiving such additional positions; and

"(II) the number of such additional positions.".

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the third sentence, is amended—

(A) by striking "subsection (h)(7)" and inserting "subsections (h)(7) and (h)(8)"; and

(B) by striking "it applies" and inserting "they apply".

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

"(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.".

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking "section 1886(h)(7)" and all that follows and inserting "paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act.".

SEC. 1502. INCREASING TRAINING IN NONPROVIDER SETTINGS.

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) by designating the first sentence as a clause (i) with the heading "IN GENERAL.—" and appropriate indentation;

(2) by striking "shall be counted and that all the time" and inserting "shall be counted and that—

"(I) effective for cost reporting periods beginning before July 1, 2009, all the time";

(3) in subclause (I), as inserted by paragraph (1), by striking the period at the end and inserting "; and"; and

(A) by inserting after subclause (I), as so inserted, the following:

"(II) effective for cost reporting periods beginning on or after July 1, 2009, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital in-

curs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.".

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking "(iv) Effective for discharges occurring on or after October 1, 1997" and inserting "(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009"; and

(2) by inserting after subclause (I), as inserted by paragraph (1), the following new subclause:

"(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.".

(c) OIG STUDY ON IMPACT ON TRAINING.—The Inspector General of the Department of Health and Human Services shall analyze the data collected by the Secretary of Health and Human Services from the records made available to the Secretary under section 1886(h)(4)(E) of the Social Security Act, as amended by subsection (a), in order to assess the extent to which there is an increase in time spent by medical residents in training in nonprovider settings as a result of the amendments made by this section. Not later than 4 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on such analysis and assessment.

(d) DEMONSTRATION PROJECT FOR APPROVED TEACHING HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under which an approved teaching health center (as defined in paragraph (3)) would be eligible for payment under subsections (h) and (k) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) of amounts for its own direct costs of graduate medical education activities for primary care residents, as well as for the direct costs of graduate medical education activities of its contracting hospital for such residents, in a manner similar to the manner in which such payments would be made to a hospital if the hospital were to operate such a program.

(2) CONDITIONS.—Under the demonstration project—

(A) an approved teaching health center shall contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program of the hospital involved and is responsible for payment to the hospital for the hospital's costs of the salary and fringe benefits for residents in the program;

(B) the number of primary care residents of the center shall not count against the contracting hospital's resident limit; and

(C) the contracting hospital shall agree not to diminish the number of residents in its primary care residency training program.

(3) APPROVED TEACHING HEALTH CENTER DEFINED.—In this subsection, the term "approved teaching health center" means a nonprovider setting, such as a Federally qualified health center or rural health clinic (as defined in section 1861(aa) of the Social Security Act), that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.

SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking "Such rules" and inserting "Subject to clause (ii), such rules"; and

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

"(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associ-

ated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.";

(2) in paragraph (4), by adding at the end the following new subparagraph:

"(I) TREATMENT OF CERTAIN TIME IN APPROVED MEDICAL RESIDENCY TRAINING PROGRAMING.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency."; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

"(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.".

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 1501(b), is amended by adding at the end the following new clause:

"(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

"(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in nonpatient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

"(aa) is recognized as a subsection (d) hospital;

"(bb) is recognized as a subsection (d) Puerto Rico hospital;

"(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

"(dd) is a provider-based hospital outpatient department.

"(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.".

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2008.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) DIRECT GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

"(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

"(I) IN GENERAL.—The Secretary shall, by regulation, establish a process consistent with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State closes on or after the date that is 2 years before the date of the enactment

of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

"(II) PROCESS FOR HOSPITALS IN CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the State. Such process shall take into consideration the recommendations submitted to the Secretary by the senior health official (as designated by the chief executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital closure involved (or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause, 180 days after such date of enactment).

"(III) LIMITATION.—The estimated aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the estimated number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).".

(b) NO EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not effect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking "(7) and" and inserting "(4)(H)(vi), (7), and".

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by inserting "or under paragraph (4)(H)(vi)" after "under this paragraph".

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with "Notwithstanding" as a subparagraph (A) with the heading "IN GENERAL.—" and with appropriate indentation; and

(2) by adding at the end the following new subparagraph:

"(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

"(i) Work effectively in various health care delivery settings, such as nonprovider settings.

"(ii) Coordinate patient care within and across settings relevant to their specialties.

"(iii) Understand the relevant cost and value of various diagnostic and treatment options.

"(iv) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

"(v) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in case of such errors, including experience and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

"(vi) Be meaningful EHR users (as determined under section 1848(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves."

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1)(B) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have the appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(A) development of curriculum requirements; and

(B) assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

TITLE VI—PROGRAM INTEGRITY

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

SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO FIGHT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

"(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $100,000,000 to such Account from such Trust Fund for each fiscal year beginning with 2011. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.".

(2) in paragraph (4)(A)—

(A) by inserting "for activities described in paragraph (3)(C) and" after "necessary"; and

(B) by inserting "until expended" after "appropriation".

(b) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting ", or otherwise," after "entities".

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (1)(D), by striking all that follows "in which the person was excluded" and inserting "under Federal law from the Federal health care program under which the claim was made, or";

(2) by striking "or" at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end "or";

(4) by inserting after paragraph (7) the following new paragraph:

"(8) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;";

(5) in the matter following paragraph (8), as inserted by paragraph (4), by striking "or in cases under paragraph (7), $50,000 for each such act)" and inserting "in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (8), $50,000 for each false statement, omission, or misrepresentation of a material fact)"; and

(6) in the second sentence, by striking "for a lawful purpose)" and inserting "for a lawful purpose, or in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF FALSE STATEMENTS MATERIAL TO A FALSE CLAIM.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 1611, is further amended—

(1) in paragraph (7), by striking "or" at the end;

(2) in paragraph (8), by inserting "or" at the end; and

(3) by inserting after paragraph (8), the following new paragraph:

"(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;"; and

(4) in the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking "or in cases under paragraph (8)" and inserting "in cases under paragraph (8)"; and

(B) by striking "a material fact)" and inserting "a material fact, in cases under paragraph (9), $50,000 for each false record or statement)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking "or" at the end;

(2) in paragraph (9), by inserting "or" at the end;

(3) by inserting after paragraph (9) the following new paragraph:

"(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;"; and

(4) in the matter following paragraph (10), as inserted by paragraph (3), by inserting ", or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph" after "false record or statement".

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(1) in subparagraph (A), by inserting "timely" before "inspect"; and

(2) in subparagraph (B), by inserting "timely" before "audit and inspect".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1819 the following new section:

"SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

"(a) IN GENERAL.—If the Secretary determines on the basis of a survey or otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and failed to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

"(1) that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (b)(2)(A); or

"(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may—

"(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

"(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

"(b) INTERMEDIATE SANCTIONS.—

"(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2012—

"(A) a range of intermediate sanctions to apply to hospice programs under the conditions described in subsection (a), and

"(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

"(2) SPECIFIED SANCTIONS.—

"(A) IN GENERAL.—The intermediate sanctions developed under paragraph (1) may include—

"(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000,

"(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

"(iii) the appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made,

"(iv) corrective action plans, and

"(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all requirements referred to in that clause.

"(B) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

"(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

"(3) SECRETARIAL AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.".

(b) APPLICATION TO MEDICAID.—Section 1905(o) of the Social Security Act (42 U.S.C. 1396d(o)) is amended by adding at the end the following new paragraph:

"(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.".

(c) APPLICATION TO CHIP.—Title XXI of the Social Security Act is amended by adding at the end the following new section:

"SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

"The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner such provisions apply to a hospice program providing hospice care under title XVIII.".

SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EXCLUDED FROM PROGRAM PARTICIPATION.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by the previous sections, is further amended—

(1) by striking "or" at the end of paragraph (9);

(2) by inserting "or" at the end of paragraph (10);

(3) by inserting after paragraph (10) the following new paragraph:

"(11) orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or any other item or service, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;"; and

(4) in the matter following paragraph (11), as inserted by paragraph (2), by striking "$15,000 for each day of the failure described in such paragraph" and inserting "$15,000 for each day of the failure described in such paragraph, or in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) IN GENERAL.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting "except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D MARKETING VIOLATIONS.

(a) IN GENERAL.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking "or" at the end;

(2) by inserting after subparagraph (H) the following new subparagraphs:

"(I) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

"(J) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

"(K) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

"(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;"; and

(3) by adding at the end the following new sentence: "The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) IN GENERAL.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting "OR AUDIT" after "INVESTIGATION"; and

(2) by striking "investigation into" and all that follows through the period and inserting "investigation or audit related to—"

"(i) any offense described in paragraph (1) or in subsection (a); or

"(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128(c) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking "AND PERIOD" and inserting "PERIOD, AND EFFECT"; and

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

"(4)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

"(i) by an excluded individual or entity; or

"(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

"(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a Federal health care program or to whom such payment was made.

"(C)(i) Payment may be made under a Federal health care program for emergency items or services (not including items or services furnished in an emergency room of a hospital) furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of such individual's exclusion.

"(ii) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for items or services furnished by an excluded individual or entity, and such individual eligible for such benefits did not know or have reason to know that such excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services. In such case the Secretary shall notify such individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

"(iii) In the case that a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than an individual eligible for benefits under title XVIII or XIX or the excluded individual or entity, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant Federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to the individual or entity that submitted the claim for the items or services furnished by the excluded individual or entity. If a Federal health care program contractor provided inaccurate or misleading information that resulted in the waiver of an overpayment under this clause, the Secretary shall take appropriate action to recover the improperly paid amount from the contractor.".

Subtitle C—Enhanced Program and Provider Protections

SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AUTHORITY.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.

"(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

"(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other sources, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items or services, including a category within a geographic area, under title XVIII, XIX, or XXI, the Secretary

may impose any of the following requirements with respect to a provider of services or a supplier (whether such provider or supplier is initially enrolling in the program or is renewing such enrollment):

"(A) Screening under paragraph (2).

"(B) Enhanced oversight periods under paragraph (3).

"(C) Enrollment moratoria under paragraph (4).

In applying this subsection for purposes of title XIX and XXI the Secretary may require a State to carry out the provisions of this subsection as a requirement of the State plan under title XIX or the child health plan under title XXI. Actions taken and determinations made under this subsection shall not be subject to review by a judicial tribunal.

"(2) SCREENING.—For purposes of paragraph (1), the Secretary shall establish procedures under which screening is conducted with respect to providers of services and suppliers described in such paragraph. Such screening may include—

"(A) licensing board checks;

"(B) screening against the list of individuals and entities excluded from the program under title XVIII, XIX, or XXI;

"(C) the excluded provider list system;

"(D) background checks; and

"(E) unannounced pre-enrollment or other site visits.

"(3) ENHANCED OVERSIGHT PERIOD.—For purposes of paragraph (1), the Secretary shall establish procedures to provide for a period of not less than 30 days and not more than 365 days during which providers of services and suppliers described in such paragraph, as the Secretary determines appropriate, would be subject to enhanced oversight, such as required or unannounced (or required and unannounced) site visits or inspections, prepayment review, enhanced review of claims, and such other actions as specified by the Secretary, under the programs under titles XVIII, XIX, and XXI. Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that after the initial period such additional period of oversight is necessary.

"(4) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, may impose a moratorium on the enrollment of providers of services and suppliers within a category of providers of services and suppliers (including a category within a specific geographic area) under such title. Such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

"(5) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.".

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (23), by inserting before the semicolon at the end the following: "or by a person to whom or entity to which a moratorium under section 1128G(a)(4) is applied during the period of such moratorium";

(B) in paragraph (72); by striking at the end "and";

(C) in paragraph (73), by striking the period at the end and inserting "; and"; and

(D) by adding after paragraph (73) the following new paragraph:

"(74) provide that the State will enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection (a) through use of the appropriate procedures described in such subsection (a)), and that the State will carry out any activities as required by the Secretary for purposes of such subsection (a).".

(2) CHIP.—Section 2102 of such Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

"(d) PROGRAM INTEGRITY.—A State child health plan shall include a description of the procedures to be used by the State—

"(1) to enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection through use of the appropriate procedures described in such subsection); and

"(2) to carry out any activities as required by the Secretary for purposes of such subsection.".

(3) MEDICARE.—Section 1866(j) of such Act (42 U.S.C. 1395cc(j)) is amended by adding at the end the following new paragraph:

"(3) PROGRAM INTEGRITY.—The provisions of section 1128G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.".

SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP PROGRAM DISCLOSURE REQUIREMENTS RELATING TO PREVIOUS AFFILIATIONS.

(a) IN GENERAL.—Section 1128G of the Social Security Act, as inserted by section 1631, is amended by adding at the end the following new subsection:

"(b) ENHANCED PROGRAM DISCLOSURE REQUIREMENTS.—

"(1) DISCLOSURE.—A provider of services or supplier who submits on or after July 1, 2011, an application for enrollment and renewing enrollment in a program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that has uncollected debt or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

"(2) ENHANCED SAFEGUARDS.—If the Secretary determines that such previous affiliation of such provider or supplier poses a risk of fraud, waste, or abuse, the Secretary may apply such enhanced safeguards as the Secretary determines necessary to reduce such risk associated with such provider or supplier enrolling or participating in the program under title XVIII, XIX, or XXI. Such safeguards may include enhanced oversight, such as enhanced screening of claims, required or unannounced (or required and unannounced) site visits or inspections, additional information reporting requirements, and conditioning such enrollment on the provision of a surety bond.

"(3) AUTHORITY TO DENY PARTICIPATION.—If the Secretary determines that there has been at least one such affiliation and that such affiliation or affiliations, as applicable, of such provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary may deny the application of such provider or supplier.".

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Paragraph (74) of section 1902(a) of such Act (42 U.S.C. 1396a(a)), as added by section 1631(b)(1), is amended—

(A) by inserting "or subsection (b) of such section (relating to disclosure requirements)" before ", and that the State"; and

(B) by inserting before the period the following: "and apply any enhanced safeguards, with respect to a provider or supplier described in such subsection (b), as the Secretary determines necessary under such subsection (b)".

(2) CHIP.—Subsection (d) of section 2102 of such Act (42 U.S.C. 1397bb), as added by section 1631(b)(2), is amended—

(A) in paragraph (1), by striking at the end "and";

(B) in paragraph (2) by striking the period at the end and inserting "; and'" and

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

"(3) to enforce any determination made by the Secretary under subsection (b) of section 1128G (relating to disclosure requirements) and to apply any enhanced safeguards, with respect to a provider or supplier described in such subsection, as the Secretary determines necessary under such subsection.".

SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 4101 of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

"(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under the fee schedule under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(ii)) that result in the ordering of additional services (such as lab tests), the prescription of drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.".

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) IN GENERAL.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(1) in paragraph (3), by striking at the end "and";

(2) by redesignating paragraph (4) as paragraph (5); and

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

"(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and".

(b) REFERENCE TO MEDICAID INTEGRITY PROGRAM.—For a similar provision with respect to the Medicaid Integrity Program, see section 1752.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

"(e) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) IN GENERAL.—The Secretary may disenroll a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title (or may impose any civil monetary penalty or other intermediate sanction under paragraph (4)) if such provider of services or supplier fails to, subject to paragraph (5), establish a compliance program that contains the core elements established under paragraph (2).

"(2) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under paragraph (1). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse for the organization's employees and contractors; a confidential or anonymous mechanism, such as a hotline, to receive compliance questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.

"(3) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under paragraph (2) and the date on which a provider of services and suppliers (other than physicians) shall be required to have established such a program for purposes of this subsection.

"(4) CMS ENFORCEMENT AUTHORITY.—The Administrator for the Centers of Medicare & Medicaid Services shall have the authority to determine whether a provider of services or supplier described in subparagraph (3) has met the requirement of this subsection and to impose a civil monetary penalty not to exceed $50,000 for each violation. The Secretary may also impose other intermediate sanctions, including corrective action plans and additional monitoring in the case of a violation of this subsection.

"(5) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of providers of services or suppliers (other than physicians) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse before implementing the requirements of this subsection to all providers of services and suppliers described in paragraph (3).".

(b) REFERENCE TO SIMILAR MEDICAID PROVISION.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1753.

SEC. 1636. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) PURPOSE.—In general, the 36-month period currently allowed for claims filing under parts A, B, C, and, D of title XVIII of the Social Security Act presents opportunities for fraud schemes in which processing patterns of the Centers for Medicare & Medicaid Services can be observed and exploited. Narrowing the window for claims processing will not overburden providers and will reduce fraud and abuse.

(b) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (1), by striking "period of 3 calendar years" and all that follows and inserting "period of 1 calendar year from which such services are furnished; and"; and

(B) by adding at the end the following new sentence: "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.".

(2) PART B.—Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(A) in paragraph (1), by striking "period of 3 calendar years" and all that follows and inserting "period of 1 calendar year from which such services are furnished; and"; and

(B) by adding at the end the following new sentence: "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.".

(3) PARTS C AND D.—Section 1857(d) of such Act is amended by adding at the end the following new paragraph:

"(7) PERIOD FOR SUBMISSION OF CLAIMS.—The contract shall require an MA organization or PDP sponsor to require any provider of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrollee of such organization, written request, signed by such enrollee, except in cases in which the Secretary finds it impracticable for the enrollee to do so, is filed for payment for such items and services in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the 1 calendar year period after such items and services are furnished. In applying the previous sentence, the Secretary may specify exceptions to the 1 calendar year period specified.".

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall be effective for items and services furnished on or after January 1, 2011.

SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL EQUIPMENT OR HOME HEALTH SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking "physician" and inserting "physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)".

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting "in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)," before "or, in the case of services".

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)," after "a physician".

(c) DISCRETION TO EXPAND APPLICATION.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to other categories of items or services under this title, including covered part D drugs as defined in section 1860D–2(e), if the Secretary determines that such application would help to reduce the risk of waste, fraud, and abuse with respect to such other categories under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act, is amended by adding at the end the following new paragraph

"(10) The Secretary may disenroll, for a period of not more than one year for each act, a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.".

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc), is amended—

(1) in subparagraph (U), by striking at the end "and";

(2) in subparagraph (V), by striking the period at the end and adding "; and"; and

(3) by adding at the end the following new subparagraph:

"(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.".

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting ", ordering, referring for furnishing, or certifying the need for" after "furnishing".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 1639. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking "and such services" and inserting "such services"; and

(B) by inserting after "care of a physician" the following: ", and, in the case of a certification or recertification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary".

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking "and" before "(iii)"; and

(B) by inserting after "care of a physician" the following: ", and (iv) in the case of a certification or recertification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification or recertification, or other reasonable timeframe as determined by the Secretary".

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding before the period at the end the following: "and shall require that such an order be written pursuant to the physician documenting that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary".

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID AND CHIP.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX or XXI of the Social Security Act, in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AUTHORITY TO PROGRAM EXCLUSION INVESTIGATIONS.

(a) IN GENERAL.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a-7(f)) is amended by adding at the end the following new paragraph:

"(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to investigations beginning on or after January 1, 2010.

SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND MEDICAID OVERPAYMENTS.

Section 1128G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:

"(c) REPORTS ON AND REPAYMENT OF OVERPAYMENTS IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.—

"(1) REPORTING AND RETURNING OVERPAYMENTS.—If a person knows of an overpayment, the person must—

"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and

"(B) notify the Secretary, the State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

"(2) TIMING.—An overpayment must be reported and returned under paragraph (1)(A) by not later than the date that is 60 days after the date the person knows of the overpayment.

Any known overpayment retained later than the applicable date specified in this paragraph creates an obligation as defined in section 3729(b)(3) of title 31 of the United States Code.

"(3) CLARIFICATION.—Repayment of any overpayments (or refunding by withholding of future payments) by a provider of services or supplier does not otherwise limit the provider or supplier's potential liability for administrative obligations such as applicable interests, fines, and specialties or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud by the provider or supplier or the employees or agents of such provider or supplier.

"(4) DEFINITIONS.—In this subsection:

"(A) KNOWS.—The term 'knows' has the meaning given the terms 'knowing' and 'knowingly' in section 3729(b) of title 31 of the United States Code.

"(B) OVERPAYMENT.—The term "overpayment" means any finally determined funds that a person receives or retains under title XVIII, XIX, or XXI to which the person, after applicable reconciliation, is not entitled under such title.

"(C) PERSON.—The term 'person' means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)), but excluding a beneficiary.".

SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR OIG EXCLUSIONS TO BENEFICIARIES OF ANY FEDERAL HEALTH CARE PROGRAM.

Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking "individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both" and inserting "beneficiaries (as defined in section 1128A(i)(5)) of that program".

SEC. 1643. ACCESS TO CERTAIN INFORMATION ON RENAL DIALYSIS FACILITIES.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

"(15) For purposes of evaluating or auditing payments made to renal dialysis facilities for items and services under this section under paragraph (1), each such renal dialysis facility, upon the request of the Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.".

SEC. 1644. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICARE.

(a) MEDICARE.—Section 1866(j)(1) of the Social Security Act (42 U.S.C. 1395cc(j)(1)) is amended by adding at the end the following new subparagraph:

"(D) BILLING AGENTS AND CLEARINGHOUSES REQUIRED TO BE REGISTERED UNDER MEDICARE.—Any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must be registered with the Secretary in a form and manner specified by the Secretary.".

(b) MEDICAID.—For a similar provision with respect to the Medicaid program under title XIX of the Social Security Act, see section 1759.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to claims submitted on or after January 1, 2012.

SEC. 1645. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.

Section 1128A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking "to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1))";

(B) in paragraph (4)—

(i) in the matter preceding subparagraph (A), by striking "participating in a program under title XVIII or a State health care program" and inserting "participating in a Federal health care program (as defined in section 1128B(f))"; and

(ii) in subparagraph (A), by striking "title XVIII or a State health care program" and inserting "a Federal health care program (as defined in section 1128B(f))";

(C) by striking "or" at the end of paragraph (10);

(D) by inserting after paragraph (11) the following new paragraphs:

"(12) conspires to commit a violation of this section; or

"(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;"; and

(E) in the matter following paragraph (13), as inserted by subparagraph (D)—

(i) by striking "or" before "in cases under paragraph (11)"; and

(ii) by inserting ", in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease" after "by an excluded individual"; and

(F) in the second sentence, by striking "such false statement, omission, or misrepresentation)" and inserting "such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased)".

(2) in subsection (c)(1), by striking "six years" and inserting "10 years"; and

(3) in subsection (i)—

(A) by amending paragraph (2) to read as follows:

"(2) The term 'claim' means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 1128B(f)), whether or not the United States or a State agency has title to the money or property, that—

"(A) is presented or caused to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

"(B) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program's behalf or to advance a Federal health care program interest, and if the Federal health care program—

"(i) provides or has provided any portion of the money or property requested or demanded; or

"(ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.";

(B) by amending paragraph (3) to read as follows:

"(3) The term 'item or service' means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program.";

(C) in paragraph (6)—

(i) in subparagraph (C), by striking at the end "or";

(ii) in the first subparagraph (D), by striking at the end the period and inserting "; or"; and

(iii) by redesignating the second subparagraph (D) as a subparagraph (E);

(D) by amending paragraph (7) to read as follows:

"(7) The terms 'knowing', 'knowingly', and 'should know' mean that a person, with respect to information—

"(A) has actual knowledge of the information;

"(B) acts in deliberate ignorance of the truth or falsity of the information; or

"(C) acts in reckless disregard of the truth or falsity of the information; and require no proof of specific intent to defraud."; and

(E) by adding at the end the following new paragraphs:

"(8) The term 'obligation' means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

"(9) The term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.".

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

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

Section 1128G of the Social Security Act, as added by section 1631 and amended by sections 1632 and 1641, is further amended by adding at the end the following new subsection;

"(d) ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.—For purposes of law enforcement activity, and to the extent consistent with applicable disclosure, privacy, and security laws, including the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1974, and subject to any information systems security requirements enacted by law or otherwise required by the Secretary, the Attorney General shall have access, facilitation by the Inspector General of the Department of Health and Human Services, to claims and payment data relating to titles XVIII and XIX, in consultation with the Centers for Medicare & Medicaid Services or the owner of such data.".

SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) IN GENERAL.—To eliminate duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) established under section 1128E of the Social Security Act and the National Practitioner Data Bank (NPBD) established under the Health Care Quality Improvement Act of 1986, section 1128E of the Social Security Act (42 U.S.C. 1320a-7e) is amended—

(1) in subsection (a), by striking "Not later than" and inserting "Subject to subsection (h), not later than";

(2) in the first sentence of subsection (d)(2), by striking "(other than with respect to requests by Federal agencies)"; and

(3) by adding at the end the following new subsection:

"(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK; TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Secretary shall implement a process to eliminate duplication between the Healthcare Integrity and Protection Data Bank (in this subsection referred to as the 'HIPDB' established pursuant to subsection (a) and the National Practitioner Data Bank (in this subsection referred to as the 'NPDB') as implemented under the Health Care Quality Improvement Act of 1986 and section 1921 of this Act, including systems testing necessary to ensure that information formerly collected in the HIPDB will be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Except as otherwise provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report), access to, and other treatment of the information specified in this section.".

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HHS OFFICE OF THE INSPECTOR GENERAL.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-7c(a)(1)) is amended—

(1) in subparagraph (C), by adding at the end "and";

(2) in subparagraph (D), by striking at the end ", and" and inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the one year period that begins on the effective date specified in subsection (e)(1), the information described in paragraph (2) shall be available from the National Practitioner Data Bank (described in section 1921 of the Social Security Act) to the Secretary of Veterans Affairs without charge.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(d) FUNDING.—Notwithstanding any provisions of this Act, sections 1128E(d)(2) and 1817(k)(3) of the Social Security Act, or any other provision of law, there shall be available for carrying out the transition process under section 1128E(h) of the Social Security Act over the period required to complete such process, and for operation of the National Practitioner Data Bank until such process is completed, without fiscal year limitation—

(1) any fees collected pursuant to section 1128E(d)(2) of such Act; and

(2) such additional amounts as necessary, from appropriations available to the Secretary and to the Office of the Inspector General of the Department of Health and Human Services under clauses (i) and (ii), respectively, of section 1817(k)(3)(A) of such Act, for costs of such activities during the first 12 months following the date of the enactment of this Act.

(e) EFFECTIVE DATE.—The amendments made—

(1) by subsection (a)(2) shall take effect on the first day after the Secretary of Health and Human Services certifies that the process implemented pursuant to section 1128E(h) of the Social Security Act (as added by subsection (a)(3)) is complete; and

(2) by subsection (b) shall take effect on the earlier of the date specified in paragraph (1) or the first day of the second succeeding fiscal year after the fiscal year during which this Act is enacted.

SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS.

The provisions of sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (and standards promulgated pursuant to such sections) and the Privacy Act of 1974 shall apply with respect to the provisions of this subtitle and amendments made by this subtitle.

[TITLE VII—MEDICAID AND CHIP]

[For title VII of division B, see text of bill as introduced on July 14, 2009.]

TITLE VIII—REVENUE-RELATED PROVISIONS

SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Paragraph (19) of section 6103(l) of the Internal Revenue Code of 1986 is amended to read as follows:

"(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—

"(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall be disclosed to officers and employees of the Social Security Administration, with respect to any taxpayer identified by the Commissioner of Social Security—

"(i) return information for the applicable year from returns with respect to wages (as defined in section 3121(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

"(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year,

"(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self-employment, on such return,

"(iv) if the individual is a married individual filing a separate return for the applicable year, the social security number (if reasonably available) of the spouse on such return,

"(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, and subchapter S corporations of the individual's spouse on such return, and

"(vi) such other return information relating to the individual (or the individual's spouse in the case of a joint return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

"(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer information records.

"(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

"(i) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy, and

"(ii) any individual the Social Security Administration has identified as a spouse of an individual described in clause (i).

"(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act for use in outreach efforts under section 1144 of the Social Security Act.".

(b) SAFEGUARDS.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by striking "(19)," each place it appears, and

(2) by striking "or (17)" each place it appears and inserting "(17), or (19)".

(c) CONFORMING AMENDMENT.—Paragraph (3) of section 6103(a) of such Code is amended by striking "(19),".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to disclosures made after the date which is 12 months after the date of the enactment of this Act.

SEC. 1802. COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.

(a) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

"(1) For fiscal year 2010, $90,000,000.

"(2) For fiscal year 2011, $100,000,000.

"(3) For fiscal year 2012, $110,000,000.

"(4) For each fiscal year beginning with fiscal year 2013—

"(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

"(c) FAIR SHARE PER CAPITA AMOUNT.—

"(1) COMPUTATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2013) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

"(B) ALTERNATIVE COMPUTATION.—

"(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

"(ii) DEFAULT AMOUNT.—The default amount under this clause for—

"(I) fiscal year 2013 is equal to $2; or

"(II) a subsequent year is equal to the default amount under this clause for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

"(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

"(d) EXPENDITURES FROM FUND.—

"(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and Human Services for carrying out section 1181 of the Social Security Act.

"(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1181(b) of the Social Security Act for such fiscal year:

"(A) For fiscal year 2010, $7,000,000.

"(B) For fiscal year 2011, $9,000,000.

"(C) For each fiscal year beginning with 2012, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

"(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

"(1) the fees received in the Treasury under subchapter B of chapter 34, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.".

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

"Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.".

(b) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(1) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"Sec. 4375. Health insurance.
"Sec. 4376. Self-insured health plans.
"Sec. 4377. Definitions and special rules.

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

"(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

"(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

"(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

"(i) such arrangement shall be treated as a specified health insurance policy, and

"(ii) the person referred to in such subparagraph shall be treated as the issuer.

"(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

"(b) LIABILITY FOR FEE.—

"(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

"(1) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by one or more employers for the benefit of their employees or former employees,

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

"(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

"(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

"(A) any insurance program established under title XVIII of the Social Security Act,

"(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

"(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.".

(2) CLERICAL AMENDMENTS.—

(A) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

"Subchapter A—Policies Issued By Foreign Insurers".

(B) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 1901. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting "(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)" after "December 31, 2009".

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting "and for fiscal year 2010, $1,600,000," after "$6,000,000,".

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking "2010" and inserting "2014 or until expended".

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking "December 1, 2008" and inserting "March 31, 2011".

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking "May 1, 2010" and inserting "March 31, 2013".

SEC. 1904. GRANTS TO STATES FOR QUALITY HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

Part B of title IV of the Social Security Act (42 U.S.C. 621–629i) is amended by adding at the end the following:

"Subpart 3—Support for Quality Home Visitation Programs

"SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

"(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

"(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, at such time and in such manner as the Secretary may require, an application for the grant that includes the following:

"(1) DESCRIPTION OF HOME VISITATION PROGRAMS.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be supported by a grant made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

"(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

"(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

"(B) the number and types of families who are receiving services under the programs;

"(C) the sources and amount of funding provided to the programs;

"(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services; and

"(E) training and technical assistance activities designed to achieve or support the goals of the programs.

"(3) ASSURANCES.—Assurances from the State that—

"(A) in supporting home visitation programs using funds provided under this section, the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

"(B) the State will reserve 5 percent of the grant funds for training and technical assistance to the home visitation programs using such funds;

"(C) in supporting home visitation programs using funds provided under this section, the State will promote coordination and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

"(D) home visitation programs supported using such funds will, when appropriate, provide referrals to other programs serving children and families; and

"(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

"(4) OTHER INFORMATION.—Such other information as the Secretary may require.

"(c) ALLOTMENTS.—

"(1) INDIAN TRIBES.—From the amount reserved under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian tribe that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the amount so reserved as the number of children in the Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

"(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not an Indian tribe and that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the remainder of the amount so appropriated as the number of children in the State whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such States whose families have income that does not exceed 200 percent of the poverty line.

"(3) REALLOTMENTS.—The amount of any allotment to a State under a paragraph of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section shall be available for reallotment using the allotment methodology specified in that paragraph. Any amount so reallotted to a State is deemed part of the allotment of the State under this subsection.

"(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection for a fiscal year if the Secretary finds that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

"(e) PAYMENT OF GRANT.—

"(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under subsection (m), in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

"(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term 'reimbursable percentage' means, with respect to a fiscal year—

"(A) 85 percent, in the case of fiscal year 2010;

"(B) 80 percent, in the case of fiscal year 2011; or

"(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year.

"(f) ELIGIBLE EXPENDITURES.—

"(1) IN GENERAL.—In this section, the term 'eligible expenditures'—

"(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

"(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development;

"(ii) employ well-trained and competent staff, maintain high quality supervision, provide for ongoing training and professional development, and show strong organizational capacity to implement such a program;

"(iii) establish appropriate linkages and referrals to other community resources and supports;

"(iv) monitor fidelity of program implementation to ensure that services are delivered according to the specified model; and

"(v) provide parents with—

"(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);

"(II) knowledge of realistic expectations of age-appropriate child behaviors;

"(III) knowledge of health and wellness issues for children and parents;

"(IV) modeling, consulting, and coaching on parenting practices;

"(V) skills to interact with their child to enhance age-appropriate development;

"(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

"(VII) activities designed to help parents become full partners in the education of their children;

"(B) includes expenditures for training, technical assistance, and evaluations related to the programs; and

"(C) does not include any expenditure with respect to which a State has submitted a claim for payment under any other provision of Federal law.

"(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

"(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that do not adhere to a model of home visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

"(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term 'applicable percentage' means, with respect to a fiscal year—

"(i) 60 percent for fiscal year 2010;

"(ii) 55 percent for fiscal year 2011;

"(iii) 50 percent for fiscal year 2012;

"(iv) 45 percent for fiscal year 2013; or

"(v) 40 percent for fiscal year 2014.

"(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

"(h) WAIVER AUTHORITY.—

"(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

"(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

"(A) the Secretary waives the requirement; or

"(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

"(i) STATE REPORTS.—Each State to which a grant is made under this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

"(1) the services delivered by the programs that received funds from the grant;

"(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

"(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

"(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

"(5) the annual cost of implementing the program, including the cost per family served under the program;

"(6) the outcomes experienced by recipients of services through the program;

"(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

"(8) the indicators and methods used to monitor whether the program is being implemented as designed; and

"(9) other information as determined necessary by the Secretary.

"(j) EVALUATION.—

"(1) IN GENERAL.—The Secretary shall, by grant or contract, provide for the conduct of an independent evaluation of the effectiveness of home visitation pro-

grams receiving funds provided under this section, which shall examine the following:

"(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

"(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

"(2) REPORTS TO THE CONGRESS.—

"(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

"(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

"(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

"(1) The high need communities targeted by States for programs carried out under this section.

"(2) The service delivery models used in the programs receiving funds provided under this section.

"(3) The characteristics of the programs, including—

"(A) the qualifications and demographic characteristics of program staff; and

"(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

"(4) The outcomes reported by the programs.

"(5) The research-based instruction, materials, and activities being used in the activities funded under the grant.

"(6) The training and technical activities, including on-going professional development, provided to the programs.

"(7) The annual costs of implementing the programs, including the cost per family served under the programs.

"(8) The indicators and methods used by States to monitor whether the programs are being been implemented as designed.

"(l) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (m), the Secretary shall reserve—

"(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (j), and the provision to States of training and technical assistance, including the dissemination of best practices in early childhood home visitation; and

"(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

"(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

"(1) $50,000,000 for fiscal year 2010;

"(2) $100,000,000 for fiscal year 2011;

"(3) $150,000,000 for fiscal year 2012;

"(4) $200,000,000 for fiscal year 2013; and

"(5) $250,000,000 for fiscal year 2014.

"(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 431(a) shall apply.".

SEC. 1905. IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES.

Title XI of the Social Security Act is amended by inserting after section 1150 the following new section:

"IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

"SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (e)). The office or program shall—

"(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A

and B of title XVIII, under the Medicare Advantage program under part C of such title, and under title XIX;

"(2) identify areas of such policies where better coordination and protection could improve care and costs; and

"(3) issue guidance to States regarding improving such coordination and protection.

"(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

"(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

"(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

"(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

"(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

"(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

"(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

"(2) Development of methods to facilitate access to post-acute and community-based services and to identify actions that could lead to better coordination of community-based care.

"(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income subsidy program under section 1860D–14 to identify methods to more efficiently and effectively reach and enroll dual eligibles.

"(4) An assessment of communication strategies for dual eligibles to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1–800–MEDICARE, and the Medicare handbook.

"(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors related to enrollee satisfaction with services and care delivery.

"(6) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

"(7) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

"(8) Coordination of activities relating to Medicare Advantage plans under 1859(b)(6)(B)(ii) and Medicaid.

"(d) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit to Congress a report on progress in activities conducted under this section.

"(e) DEFINITIONS.—In this section:

"(1) DUAL ELIGIBLE.—The term 'dual eligible' means an individual who is dually eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

"(2) MEDICARE; MEDICAID.—The terms 'Medicare' and 'Medicaid' mean the programs under titles XVIII and XIX, respectively.".

SEC. 1906. ASSESSMENT OF MEDICARE COST-INTENSIVE DISEASES AND CONDITIONS.

(a) INITIAL ASSESSMENT.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program. The assessment shall inform research priorities within the Department of Health and Human Services in order improve the prevention, or treatment or cure, of such diseases and conditions.

(2) REPORT.—Not later than January 1, 2011, the Administrator shall submit to the Secretary of Health and Human Services a report on such assessment and the Secretary shall transmit such report to the Congress.

(b) UPDATES OF ASSESSMENT.—Not later than January 1, 2013, and biennially thereafter, the Administrator of the Centers for Medicare & Medicaid Services shall review and update the assessment described in subsection (a) and make such recommendations to the Secretary on changes in research priorities referred to in such subsection as may be appropriate. The Secretary shall submit to the Congress a report on such recommendations.

(c) MEDICARE COST-INTENSIVE RESEARCH FUND.—There is established in the Treasury of the United States a Fund to be known as the Medicare Cost-Intensive Research Fund (in this subsection referred to as the "Fund"), consisting of such amounts as may be appropriated or credited to such Fund for research priorities identified as a result of the assessments conducted under this section.

[DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT]

[For division C, see text of bill as introduced on July 14, 2009.]

I. INTRODUCTION

A. PURPOSE AND SUMMARY

The purpose of the bill, H.R. 3200, ("America's Affordable Health Choices Act of 2009") is to provide affordable, quality health care for all Americans and reduce the rate of growth in health care spending.

B. BACKGROUND AND NEED FOR LEGISLATION

AFFORDABLE COVERAGE FOR ALL AMERICANS

I am confident that we can devise a [health care] system which will enhance and not hinder the remarkable progress which has been made and is being made in practice of the professions of medicine and surgery in the United States.

We have accepted, so to speak, a second Bill of Rights under which a new basis of security and prosperity can be established for all—regardless of station, race, or creed. Among these are . . . The right to adequate medical care and the opportunity to achieve and enjoy good health.—President Franklin D. Roosevelt

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.—President Harry S. Truman

"If a free society cannot help the many who are poor, it cannot save the few who are rich"—President John F. Kennedy

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And this is not just our tradition—or the tradition of the Democratic Party—or even the tradition of the Nation. It is as old as the day it was first commanded: "Thou shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land."—President Lyndon B. Johnson

An all-directions reform of our health care system—so that every citizen will be able to get quality health care at reasonable cost regardless of income and regardless of area of residence—remains an item of highest priority on my unfinished agenda for America in the 1970s.—President Richard Nixon

This country spends more on health care than any other nation . . . We have the finest medical facilities and highly skilled, dedicated health professionals. Yet many of our people still lack adequate medical care, and the cost of care is rising so rapidly it jeopardizes our health goals and our other important social objectives.—President Jimmy Carter

While Medicare takes care of Americans over the age of 65, we're the only Western industrial nation that doesn't provide a system of health insurance for all working people under 65 . . . we should provide assistance to unemployed workers to help them keep their health insurance until they find a new job. We also need to make it easier for small businesses to buy into insurance risk pools that are large enough to make it possible to offer coverage at a reasonable cost.—President Bill Clinton

I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way. A bill for comprehensive health reform was first introduced by John Dingell Sr. in 1943. Sixty-five years later, his son continues to introduce that same bill at the beginning of each session.

Our collective failure to meet this challenge—year after year, decade after decade—has led us to the breaking point. Everyone understands the extraordinary hardships that are placed on the uninsured, who live every day just one accident or illness away from bankruptcy. These are not primarily people on welfare. These are middle-class Americans. Some can't get insurance on the job. Others are self-employed, and can't afford it, since buying insurance on your own costs you three times as much as the coverage you get from your employer. Many other Americans who are willing and able to pay are still denied insurance due to previous illnesses or conditions that insurance companies decide are too risky or too expensive to cover.

We are the only democracy—the only advanced democracy on Earth—the only wealthy nation—that allows such hardship for millions of its people. There are now more than 30 million American citizens who cannot get coverage. In just a two-year period, one in every three Americans goes without health care coverage at some point. And every day, 14,000 Americans lose their coverage. In other words, it can happen to anyone.

But the problem that plagues the health care system is not just a problem for the uninsured. Those who do have insurance have never had less security and stability than they do today. More and more Americans worry that if you move, lose your job, or change your job, you'll lose your health insurance too. More and more Americans pay their premiums, only to discover that their insurance company has dropped their coverage when they get sick, or won't pay the full cost of care. It happens every day.—President Barack Obama

This legislation fulfills a vision carried forth by Presidents Roosevelt, Truman, Kennedy, Nixon, Carter, Clinton, and now President Obama, to provide affordable, quality health care for all Americans.

It ensures affordable health care for 97 percent of Americans, and tackles rising health care costs—a key component of health reform.

To minimize disruption of the current system, the legislation builds on what works in today's health care system, while repairing the aspects that are broken.

It enacts comprehensive insurance market reforms to ensure that no one is denied coverage because of a pre-existing condition, charged more because of their gender or denied coverage when they get sick.

It limits annual out-of-pocket costs for individuals and families so that people will no longer be forced into bankruptcy because of medical expenses.

It creates a new Health Insurance Exchange to enforce federal consumer protections and insurance requirements and to provide a transparent, fair marketplace where individuals, families and employers can comparison shop for high quality, affordable health care plans.

It creates a public health insurance option that will operate on a level-playing field alongside private plans in the Exchange. The public health insurance option will foster competition, quality and choice for consumers. It will also reduce costs in the system as it will force private plans to compete on quality and price rather than by avoiding risk as they do in today's broken health care marketplace.

It provides affordability credits to assist families with incomes below 400% of the federal poverty limit (about $88,000 for a family of four in 2009) with premiums and cost-sharing to make affordable health insurance a reality for all. Annual caps on out-of-pocket spending add further financial protections for individuals and families.

It requires shared responsibility among individuals, employers, and the government so that all Americans obtain essential health benefits.

By building on what works, America's Affordable Health Choices Act will increase employer-sponsored health coverage, broaden Medicaid to meet the needs of those with the lowest incomes, make improvements to Medicare, and create a new Health Insurance Exchange where people can choose from public and private health insurance options. Under this Act, all Americans will have access to quality, affordable health care.

HEALTH DELIVERY REFORM

This legislation institutes health delivery and payment system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

The reforms are designed to make the nation's health care system more efficient by incentivizing providers to deliver high quality, coordinated, patient-centered care. It does so in large part by recognizing the importance of primary and preventive care. Ensuring that patients receive the right care at the right time means making sure that every American has access to a primary care provider, and that providers and patients alike have access to the best information about evidence-based medicine.

These improvements will not come overnight. But programs such as Medicare, Medicaid and the public insurance option can drive innovative strategies for reforming the health care delivery system in a way that will improve care for every patient and family.

STRENGTHENING MEDICARE AND MEDICAID

This legislation keeps a trust with the American people to preserve the sustainability of the Medicare program. It strengthens the program by making fiscally prudent modifications to provider payments, eliminating waste in the Medicare Advantage program, investing in prevention and extending the Medicare Trust Fund solvency by five years. It makes important investments in Medicare for our nation's seniors and people with disabilities by eliminating cost-sharing for preventive care, closing the gap in prescription drug coverage (the so-called "donut" hole), increasing access for low-income beneficiaries, expanding coverage of mental health providers so beneficiaries can better access these vital services, and limiting Medicare Advantage plans' ability to charge excessive cost sharing. The legislation also reforms the way Medicare updates payments to physicians in a way that is sustainable for providers while still holding physicians accountable for spending growth.

It strengthens the Medicaid program by improving access to primary care services and providers, and expands eligibility so that all individuals under 133 percent of the federal poverty level are assured Medicaid coverage.

WORKFORCE INVESTMENTS

Expansions in coverage will strain an already stressed health workforce. Under the legislation, existing scholarship, loan repayment, and training grant programs are strengthened to address the need for primary care, nursing and public health professionals. Medicare payments are also adjusted to increase reimbursements for primary care providers and to encourage the training of primary care providers as well.

CONCLUSION

America's Affordable Health Care Choices Act will provide 97 percent of Americans with affordable, quality health care. It also begins to change the way health care is delivered in America to obtain better value and reduce the growth in future health care costs. H.R. 3200 fulfills the economic and moral obligation to reform the health care system to make it more equitable and accessible for all.

C. Legislative History

BACKGROUND

A discussion draft of H.R. 3200 was released to the public on June 19, 2009. H.R. 3200, "America's Affordable Health Choices Act of 2009" was introduced in the House of Representatives on July 15, 2009, and was referred to the Committee on Energy and Commerce, the Committee on Ways and Means, the Committee on Education and Labor, the Committee on Oversight and Government Reform and the Committee on the Budget.

SUBCOMMITTEE ACTION

The Subcommittee on Health of the Committee on Ways and Means held one hearing this year on MedPAC's Annual Report to Congress on Medicare Payment Policy on March 17, 2009.

In the 110th Congress, the Subcommittee on Health held a number of hearings on health reform and related Medicare issues that explored various parts of the health system and informed policy contained in H.R. 3200. The following is a list of these hearings in chronological order.

March 8, 2007—Hearing on Medicare Program Integrity.

March 21, 2007—Hearing on Medicare Advantage.

May 3, 2007—Hearing on Medicare Programs for Low-Income Beneficiaries.

June 12, 2007—Hearing on Strategies to Increase Information on Comparative Clinical Effectiveness.

June 21, 2007—Hearing on Beneficiary Protections in Medicare Part D.

October 16, 2007—Joint Hearing with the Oversight Subcommittee on Statutorily Required Audits of Medicare Advantage Plan Bids.

November 15, 2007—Hearing on Trends in Nursing Home Ownership and Quality.

February 28, 2008—Hearing on Medicare Advantage.

April 15, 2008—Hearing on the Instability of Health Coverage in America.

May 14, 2008—Hearing on Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost-Shift?

June 10, 2008—Addressing Disparities in Health and Healthcare: Issues for Reform.

July 15, 2008—Hearing on State Coverage Initiatives.

September 11, 2008—Hearing on Reforming Medicare's Physician Payment System.

September 23, 2008—Hearing on the Health of the Private Health Insurance Market.

FULL COMMITTEE ACTION

The Committee on Ways and Means held six hearings on health reform in the 111th Congress. These hearings explored the current state of various parts of the health system and opportunities through which the system could be reformed and strengthened. In addition, the Committee held a markup of H.R. 3200 on July 16, 2009. The following is a list of these hearings and markups in chronological order.

March 11, 2009—*Health Reform in the 21st Century: Expanding Coverage, Improving Quality, Controlling Costs.*

April 1, 2009—*Health Reform in the 21st Century: Reforming the Health Care Delivery System.*

April 22, 2009—*Health Reform in the 21st Century: Insurance Market Reforms.*

April 29, 2009—*Health Reform in the 21st Century: Employer Sponsored Insurance.*

May 6, 2009—*Health Reform in the 21st Century: A Conversation with Health and Human Services Secretary Kathleen Sebelius.*

June 24, 2009—*Health Reform in the 21st Century: Proposals to Reform the Health System.*

July 17, 2009—*The Committee on Ways and Means Marked up the bill, and ordered, as amended, favorably reported.*

II. EXPLANATION OF THE BILL

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

Sec. 100. Purpose; Table of Contents of Division; General Definitions

Purpose

The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending. This division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken by:

- Enacting strong insurance market reforms;
- Creating a new Health Insurance Exchange, with a public health insurance option alongside private plans;
- Including sliding scale affordability credits; and
- Initiating shared responsibility among workers, employers, and the government.

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

General Definitions (Created within this Act)

- *Acceptable Coverage.*—a qualified health benefit plan coverage, coverage under a grandfathered health insurance coverage or current group health plan, Medicare Part A, Medicaid, Military Health System, certain coverage under Veteran's Health Care Program (VA), and other coverage the Secretary of HHS in coordination with the Health Choices Commissioner sees fit.
- *Basic Plan.*—a plan that offers the essential benefits package's minimum requirements to be a qualified health benefits plan approximately 70% of the actuarial value of the benefits provided.
- *Cost-sharing.*—includes deductibles, coinsurance, copayments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.
- *Employment-Based Health Plan.*—the term given to group health plans (as defined in section 733(a)(1) of ERISA (as an employee welfare benefit plan to the extent that plan provides medical care to employees or their dependents, either directly, through insurance or otherwise)—and is comprised of federal and state government plans, tribal plans and church plans.
- *Enhanced Plan.*—a plan that offers, in addition to the level of benefits under a basic plan, a lower level of cost-sharing equivalent

to approximately 85% of the actuarial value of the benefits provided.

• *Essential Benefits Package.*—health benefits coverage, consistent with the standards set forth by the Secretary no later than 18 months after enactment of this Act.

• *Health Benefits Plan.*—health insurance coverage and a group health plan, including the public health insurance option.

• *Health Insurance Exchange.*—created by this bill to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

• *Premium Plan.*—a plan that offers, in addition to the level of benefits under a basic plan, a lower level of cost-sharing equivalent to approximately 95% of the actuarial value of the benefits provided.

• *Premium Plus Plan.*—a premium plan that also offers additional benefits, such as oral health and vision care, all of which is approved by the Commissioner.

• *Qualified Health Benefits Plan (QHBP).*—a health benefits plan that meets the requirements set forth in Title I (by the Secretary) including the public health insurance option.

• *QHBP Offering Entity.*—an entity can be any of the following: a health benefits plan (that is a group health plan) in which the employer is the main source of financing, health insurance coverage which the insurance issuer is offering the coverage, the public health insurance option, a non-federal government plan established by the State or political subdivision of a State, and a federal government plan.

• *Public Health Insurance Option.*—a public plan (only available through the Health Insurance Exchange) with payment rates established by the Secretary. The public option would be required to offer basic, enhanced, and premium plans, and would be allowed to offer premium-plus plans. Payment rates for prescription drugs not covered by Medicare Part A or B will be covered by the public option at prices negotiated by the Secretary.

• *Service Area, Premium Rating Area.*—with respect to health insurance coverage: (1) if not within the Health Insurance Exchange, an area established by a QHBP offering entity of such coverage in accordance with applicable state law or (2) within the Health Insurance Exchange, an area established by such entity in accordance with state law and applicable rules set forth by the Commissioner for Exchange-participating health benefits plans.

• *"State".*—given term for purposes of the Medicaid program, but only includes the 50 states and the District of Columbia.

• *Y1, Y2, etc.*—2013, 2014, etc.

Sec. 101. Requirements Reforming Health Insurance Marketplace

Current Law

Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and includes requirements related to the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Federal regulation of the private market is more narrow in scope and applicable mostly to employer-sponsored health insurance (i.e.,

through the Employee Retirement Income Security Act of 1974 (ERISA)) and through established federal minimum standards (i.e., through the Genetic Information Nondiscrimination Act of 2008 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, etc).

Proposed Law

This provision would require Qualified Health Benefits Plans (QHBPs) to meet the new federal health insurance standards specified in Subtitles B (relating to affordable coverage), C (relating to essential benefits) and D (relating to consumer protection) of Title I. The section also provides terminology for the phrases "enrollment in employment-based health plans" and "individual and group health insurance coverage."

Reason for Change

Lays out the purpose of the legislation.

Effective Date

January 1, 2013.

Sec. 102. Protecting the Choice to Keep Current Coverage

Current Law

See description under Sec. 101.

Proposed Law

"Grandfathered health insurance coverage" would be defined as individual health insurance coverage that is in effect before the first day of Y1, as long as the insurance carrier does not (1) enroll new individuals on or after the first day of Y1 (would not affect subsequent enrollment of a dependent); (2) change any terms or conditions of the individual coverage, except as required by law; and (3) vary the percentage increase in premiums for a risk group of enrollees without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner. The Commissioner would establish a 5-year grace period beginning Y1 for existing group health plans to transition to the new federal health insurance standards applied to QHBPs. Limited benefits plans specified in the provision, such as dental only, vision only, flexible spending arrangements, and others, are unaffected by these reforms and may continue to be sold to new applicants irrespective of other reforms.

Individual health insurance coverage that is not grandfathered may only be offered after the first day of Y1 as an Exchange plan. Excepted benefits (e.g., accident or disability insurance) could be offered as long as they are offered and priced separately from health insurance coverage.

For purposes of the individual mandate (established under title III of Division A), an individual would be required to have "acceptable coverage." In order for an individual health insurance policy to be considered acceptable coverage, the policy would be either grandfathered health insurance coverage, in effect prior to Y1 or offered through the Exchange (established under title II of Division

A). Group health coverage provided during the grace period would be considered acceptable coverage.

Reason for Change

This section ensures that people can keep current health coverage as long as they'd like. Employers currently offering coverage will have five years to meet insurance reform requirements and the benefit standards (which 96 percent of employer sponsored plans already do today according to an ARC Analysis of BLS National Compensation Survey). These changes are designed to minimize disruption in health insurance coverage and ensure compliance for those who are currently covered.

Effective Date

January 1, 2013.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting Pre-Existing Condition Exclusions

Current Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, limits the duration that issuers in the group market may exclude coverage for pre-existing health conditions for "HIPAA eligible" individuals, among other provisions. Group plans may impose pre-existing condition exclusions for no longer than 12 months (18 months in the case of a late enrollee), and must decrease that exclusion period by the number of months an enrollee had prior "creditable coverage." HIPAA outright prohibits issuers in the individual market from excluding coverage for pre-existing conditions for HIPAA eligibles.

All states require health issuers to reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of January 2009 in the small group market, 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard. And, as of December 2008, 42 states limit the period of time when coverage for pre-existing health conditions may be excluded for non-HIPAA eligible enrollees in the individual market.

Proposed Law

This provision would prohibit a qualified health benefits plan from excluding coverage for pre-existing health conditions, or otherwise limit or condition such coverage with respect to an 12 individual or dependent based on any health status-related factors. Such factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability.

Reason for Change

The HIPAA limitation on pre-existing conditions did not apply to all health plans and permitted pre-existing condition exclusions to be imposed or continued in certain areas.. This provision ends the discriminatory practice of health insurers denying coverage for pre-

existing conditions. All plans will be required to meet these standards.

Effective Date

January 1, 2013.

Sec. 112. Guaranteed Issue and Renewal for Insured Plans

Current Law

HIPAA requires that coverage sold to small groups (2–50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. (Guaranteed issue rules do not address premiums.) HIPAA also guarantees that each issuer in the individual market make at least two policies available ("guaranteed availability") to all HIPAA eligible individuals. In addition, HIPAA guarantees renewal or continuation of group coverage at the option of the plan sponsor (e.g., employer) and individual coverage at the option of the individual, with some exceptions. Insurers may not renew coverage under specified circumstances, such as nonpayment of premiums or fraud.

All states require issuers to offer policies to firms with 2–50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009 in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to self-employed "groups of one." And, as of December 2008, 15 states require issuers in the individual market to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals.

Proposed Law

This provision would require issuers to offer all health insurance coverage on a guaranteed issue and renewal basis beginning in Y1, whether offered through the Exchange (established under Subtitle A of Title II), through any employment-based health plan, or otherwise. Rescissions of coverage would be prohibited, except in cases of fraud.

Reason for Change

This section provides consumer protections to ensure that people can obtain health coverage and can't have it arbitrarily taken away. All new plans will be required to meet these requirements.

Effective Date

January 1, 2013.

Sec. 113. Insurance Rating Rules

Current Law

There are a limited number of federal rating rules applicable to the private group health insurance market. However, many states currently impose stronger rating rules on insurance carriers in the small group and individual markets. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary considerably from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered

when setting a premium, such as age. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating to rate bands. Some states have no limits on rating practices which permits insurance companies to charge unlimited amounts. Pure community rating means that premiums cannot vary based on any characteristic related to a person's or group's risk, including health. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other key risk factors, such as gender. Rate bands allow premium variation based on health and/or age, but such variation is limited according to a range specified by the state. Moreover, both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as industry. For each characteristic, the state typically specifies the amount of allowable variation. As of January 2009 in the small group market, one state has pure community rating rules, eleven have adjusted community rating rules, and 35 have rate bands. As of December 2008 in the individual market, two states have pure community rating rules, five have adjusted community rating rules, and eleven have rate bands.

There are no federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the individual and small group markets that include geographic location as a factor on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

Proposed Law

This provision would impose new federal rating rules on qualified health benefits plans. QHBP premiums would vary only by age (by no more than a 2:1 ratio within age categories specified by the Commissioner (established under Sec. 141)), premium rating area (as permitted by state regulators or, in the case of an Exchange plan, as specified by the Commissioner), and family enrollment (as specified under State law and consistent with Commissioner rules).

The Commissioner, in coordination with the Secretaries of Health and Human Services (HHS) and Labor, would conduct a study of the large group market to examine (1) characteristics of employers who purchase fully-insured health insurance products and employers who self-fund health benefits, including characteristics related to bearing risk and solvency, and (2) the extent to which rating rules cause adverse selection in the large group market or encourage small and mid-size employers to self-insure health benefits. The Commissioner would submit this report to Congress and the applicable agencies no later than 18 months after enactment, and include any recommendations to ensure that the law does not provide incentives for small and mid-size employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers.

Reason for Change

The provision ensures that Qualified Health Benefits Plans and plans offered outside the exchange offer fair health insurance policies that don't discriminate against enrollees or applicants. It provides for uniform national standards, so employers, employees or

individuals moving from state-to-state won't be subject to a patchwork of requirements and protections. It requires a study of the large group marketplace to establish whether these changes have any unforeseen consequences and to advise as to whether Congress should take further action in this arena. All new plans will be required to meet these requirements. There is nothing that prohibits states from requiring stricter rating limits than the federal requirements described here.

Effective Date

January 1, 2013.

Sec. 114. Nondiscrimination in Benefits

Current Law

HIPAA established federal rules regarding non-discrimination based on health status-related factors. Group issuers are prohibited from establishing rules for eligibility and premium contributions based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information, and the Mental Health Parity Act of 1996, as amended, establishes parity by prohibiting the placement of a dollar limit (either annual or aggregate lifetime) on mental health benefits that is less than such a limit for medical/surgical benefits for groups with more than 50 employees.

Proposed Law

This provision would require QHBPs to comply with new non-discrimination standards regarding health benefits or benefit structures established by the Commissioner, building on existing federal non-discrimination rules in ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code of 1986. These standards would apply to plans offered to individuals and groups of all sizes in QHBPs, not just groups with over 50 employees. Existing mental health parity rules, specifically concerning (1) no requirement on group plans to provide mental health benefits, and (2) no impact of limited mental health parity on terms and conditions relating to the amount, duration, or scope of mental health benefits, apply to QHBPs and other policies, regardless of whether coverage is offered in the individual or group market.

Reason for Change

Currently, insurers can and do discriminate in the individual and group market. This section would guarantee that insurers could not discriminate against anyone due to a health-related condition. In addition, it strengthens protections afforded to individuals with mental health needs by extending the existing rules to everyone enrolled in a QHBP.

Effective Date

January 1, 2013.

Sec. 115. Ensuring Adequacy of Provider Networks

Current Law

HIPAA established special rules for plans that develop a network of providers. It allows small group issuers to (1) limit the employers that apply for coverage to those firms with eligible individuals who live or work in the network service area, and (2) deny coverage to small employers if the issuer demonstrates (if required) to the State that it has limited provider capacity due to obligations to existing enrollees and it is applying this decision uniformly without regard to claims experience or health status-related factors. HIPAA also prohibits a small group issuer that has denied coverage in any service area to offer small group coverage in that area for 180 days after the denial.

Proposed Law

This provision would require QHBPs that use provider networks to meet provider network standards that may be established by the Commissioner to ensure the adequacy of networks, and transparency in the cost-sharing differences between in- and out-of-network coverage. The term "provider network" means the providers with respect to covered benefits, treatments, and services available under a health benefit plan.

Reason for Change

This provision provides the Commissioner with the authority to set network adequacy requirements to ensure that plans have the right number of providers to meet the needs of enrollees.

Effective Date

January 1, 2013.

Sec. 116. Ensuring Value and Lower Premiums

Current Law

Medical loss ratio (MLR) describes is the share of total premium revenue spent on medical claims. Medigap insurance policies are private supplemental health care policies that Medicare beneficiaries can purchase to help cover some items, services, and cost sharing not covered under Medicare. Medigap plans are required to have a MLR ratio of 65% for individual policies and 75% for group policies. In addition, some states impose MLR or related requirements on insurers in the individual and/or small group health insurance markets. As of June 2008, MLR required by states ranged from 55% to 80%.

Proposed Law

This provision would require QHBPs to comply with a medical loss ratio standard to be determined by the Commissioner. QHBPs that do not meet such a standard would be required to provide rebates to enrollees, in a manner specified by the Commissioner, in sufficient amounts to meet such a loss ratio. To establish the med-

ical loss ratio standard, the Commissioner would build on the definition and methodology, developed by the HHS Secretary under Section 161, for determining how to calculate such a ratio. The methodology would set the highest ratio possible to ensure adequate QHBP participation, competition both in and out of the Exchange, and value for consumers so that their premium payments are used predominately for medical claims.

Reason for Change

This provision provides the Commissioner with the authority to ensure that premiums are used primarily to provide health benefits and not lost to excessive administrative costs or profit. The Committee is interested in establishing a minimum level of 85 percent.

Effective Date

January 1, 2013.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 121. Coverage of Essential Benefits Package

Current Law

There are very limited federal benefit mandates for health insurance. These standards were added to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other Acts such as Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 or the Genetic Information Nondiscrimination Act of 2008 and are described in the discussion of Section 122. In addition, there are more than 2,000 state-level benefit mandates that vary across the country.

Proposed Law

This provision would require a QHBP to cover at least an "essential benefit package". QHBPs could be offered in or outside of an Exchange. QHBPs offered outside of an Exchange would be allowed to offer additional benefits beyond those specified in the essential benefits package. For QHBPs offered through the Exchange, a plan offering a premium-plus level of benefits (established under Section 203) could also provide additional benefits.

The requirements under Division A would not affect the offering of limited-purpose or "excepted" benefit plans, including policies covering dental or vision treatment, long-term care, workers' compensation, and other similar benefits, if such benefit plans are offered under a separate policy, contract, or certificate of insurance.

A QHBP would not be allowed to impose coverage restrictions (except cost sharing) on anything unrelated to the clinical appropriateness of the health care items and services.

Reason for Change

The provision ensures the offering of minimum standard benefits, called the essential benefits package, to ensure that all plans meet basic needs and enable people to compare policies in the Exchange on the basis of cost and quality—not hidden differences in benefits. Outside of the Exchange, group health plans eventually have to meet the essential benefits package, as a minimum standard, but can offer additional benefits, as many do today.

Effective Date

January 1, 2013.

Sec. 122. Essential Benefit Package Defined

Current Law

There are very few federally mandated benefits. The laws that provide guidance are found in the Employee Retirement Income Security Act (ERISA), which covers employer-sponsored plans; the Public Health Service Act (PHSA), which covers some insurance plans and state and local government plans; and the Internal Revenue Code (IRC), which covers Church plans in certain circumstances. There is no federal requirement that employers offer health insurance, or that any plans that are offered cover any specific benefits. However, the mandates that do exist require that if a plan (governed by ERISA, PHSA, or IRC) covers a particular service that is addressed in the statutes, then that benefit must be designed in a certain way. Those mandates include:

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPA) (P.L. 110–343) prevents a large group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower—less favorable—than annual or lifetime dollar limits for medical and surgical benefits offered under the plan, but does not require a plan to cover mental health benefits.
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) (P.L. 104–204) requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).
- The Women's Health and Cancer Rights Act of 1998 (P.L. 105–277) contains protections for patients who elect breast reconstruction in connection with a mastectomy. For plan participants and beneficiaries receiving benefits in connection with a mastectomy, plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.
- The Genetic Information Nondiscrimination Act of 2008 (GINA) (P.L. 110–233) prohibits discrimination based on genetic information by health insurers and employers. GINA strengthens and clarifies existing HIPAA nondiscrimination and portability provisions. Broadly, GINA prohibits health insurers from engaging in three practices: (1) using genetic information about an individual to adjust a group plan's premiums, or, in the case of individual plans, to deny coverage, adjust premiums, or impose a pre-existing condition exclusion; (2) requiring or requesting genetic testing; and (3) requesting, requiring, or purchasing genetic information for underwriting purposes. It also prohibits employers from making hiring or firing decisions based on genetic information.
- Michelle's Law (P.L. 110–381) ensures that dependent post secondary education students who take a medically necessary leave of absence do not lose health insurance coverage. The law provides that a group health plan may not terminate a college student's health coverage simply because the student takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must be medically necessary, begin while the

student is suffering from a serious illness or injury and would otherwise result in a loss of coverage.

Although current federal law provides only a limited number of service and coverage mandates, it does provide some guidance toward the definition of preventive services for use by public programs and private insurance. The U.S. Preventive Services Task Force (USPSTF), administered by the Agency for Healthcare Research and Quality (AHRQ), reviews scientific evidence and makes recommendations to the health care community regarding the use of clinical preventive services, based on evidence of effectiveness and any harm associated with specific services. The USPSTF grades services as "A" through "D," or notes that there is insufficient evidence to support a recommendation. Clinical services graded "A" or "B" by the USPSTF are recommended for use in clinical practice.

Similarly, the Advisory Committee on Immunization Practices (ACIP), administered by the Centers for Disease Control and Prevention (CDC), reviews scientific evidence and makes 19 recommendations to the Secretary and the CDC Director for the routine administration of vaccines to children, adolescents, and adults in the U.S. civilian population. The ACIP is not explicitly authorized; rather, it is based in general authorities of the Secretary in Titles II and III of the PHSA.

"Actuarial value" is a summary measure of a health insurance plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. Two plans that have the same actuarial value are "actuarially equivalent." Because these are summary measures, two plans that are actuarially equivalent may not provide the same benefits for any two individuals. State health insurance regulations may include requirements expressed in terms of actuarial value.

Proposed Law

This provision would require the essential benefits package to cover specified items and services, limit cost sharing, prohibit annual and lifetime limits on covered services, ensure the adequacy of provider networks, and be equivalent (as certified by the Office of the Actuary of the Centers for Medicare and Medicaid Services) to the average prevailing employer-sponsored coverage.

The essential benefits package would be required to cover the following items and services:

- Hospitalization;
- Outpatient hospital and clinic services, including emergency department services;
- Services of physicians and other health professionals;
- Services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;
- Prescription drugs;
- Rehabilitative and "habilitative" services (i.e., services to maintain or prevent the deterioration of the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
- Mental health and substance use disorder services;

- Preventive services, include those graded "A" or "B" by the Task Force on Clinical and Preventive Services, as established by this Act, and those vaccines recommended by the Director of the CDC;
- Maternity care; and
- Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for those under age 21.

The essential benefits package would be subject to various requirements concerning cost-sharing. The package would be required to provide preventive items and services without cost-sharing (including well-baby and well-child care). The annual out-of-pocket limit in Y1 would be $5,000 for an individual and $10,000 for a family: These limits would be annually adjusted for inflation using the Consumer Price Index for all Urban Consumers (CPI-U). To the extent possible, the Secretary would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee). Cost-sharing for the Essential Benefits Package would result in coverage equal to approximately 70 percent of the actuarial value of the benefits if there were no cost-sharing imposed.

Reason for Change

To ensure that Americans will be guaranteed a defined level of benefits, with numerous options available in order to ease comparison shopping among plans based on cost and quality not manipulation of benefits.

Effective date

January 1, 2013.

Sec. 123. Health Benefits Advisory Committee

Current Law

No provision.

Proposed Law

A Health Benefits Advisory Committee would be established to recommend covered benefits and cost-sharing parameters and the essential, enhanced, and premium plans. The Committee would be chaired by the Surgeon General. The Committee membership would be comprised of:

- Nine members, appointed by the President, who are neither federal employees nor officers;
- Nine members, appointed by the Comptroller General, who are neither federal employees nor officers; and
- An even number, up to eight members, appointed by the President, who are federal employees and officers.

The initial appointments would be made within 60 days of enactment. Each Committee member would serve a three-year term, except the terms of the initial appointments would be adjusted to provide for staggered years of appointment. The members would reflect the interests of the many diverse groups of stakeholders so that no single interest would unduly influence the Committee's recommendations. At a minimum, committee membership would re-

flect physicians and other health care providers, consumer representatives, employers, labor, health insurance issuers, experts in health care delivery, and experts in health disparities, and government agencies. At least one Committee member would be a practicing physician or health professional, and another member would be an expert on children's health.

The Committee's recommendations to the Secretary on the essential benefits package (as defined in Section 122), cost-sharing levels for the enhanced plans and premium plans (as defined in Section 203), and periodic updates of the package would be required to incorporate innovation in health care. The Committee members would also be required to consider how the package would reduce health disparities, and would allow for public input as part of developing its recommendations. The Committee's initial benefit recommendations must be made to the Secretary within one year of enactment.

In developing standards for the basic, enhanced and premium plans, the Committee would be required to calculate cost-sharing such that the enhanced plan would have benefits that are actuarially equivalent to about 85% of the actuarial value of the benefits provided in the essential benefits package, and the premium plans would have benefits that are actuarially equivalent to about 95% of the actuarial value of the benefits provided in the essential benefits package.

Committee members would serve without pay, but would receive federal travel expenses, including per diem expenses. In addition, the Committee would be subject to the Federal Advisory Committee Act (which provides sunshine and transparency over advisory committee actions).

The Secretary would be required to publish all recommendations developed pursuant to this Section in the Federal Register and on the HHS website.

Reason for Change

This section provides for the advice of an expert panel to define the initial essential benefits package; cost-sharing parameters for the basic, enhanced and premium plans; and make updates to that package for the future. It ensures that experts who make up the array of groups impacted by the decision (consumers, employers, doctors, etc.) are part of developing the essential benefits package.

Effective Date

Date of enactment.

Sec. 124. Process for Adoption of Recommendations; Adoption of Benefit Standards

Current Law

No provision.

Proposed Law

This Section proposes a timeline under which the Secretary must choose whether to adopt the recommendations of the Committee established under section 123 of this bill. Within 45 days of receiving the Committee's recommendations regarding the essential benefits

package, the Secretary would be required either to adopt the benefit standards as written or not adopt the benefit standards. If the Secretary does not wish to adopt the recommendations, the Secretary shall notify the Committee of the reasons for this decision, and provide an opportunity for the Committee to revise and resubmit its recommendations.

The Secretary would be required to adopt an initial set of benefit standards within 18 months of enactment either by adopting the recommendations (and any revisions) of the Committee, or absent that, by proposing an initial set of benefit standards.

The Secretary would be required to publish all determinations under this Section in the Federal Register.

The Secretary would be required to periodically update the benefit standards. However, an essential benefits package that does not meet the essential benefits requirements specified in section 122 could not be adopted.

Reason for Change

This section lays out a timeline to ensure that the benefit standards are developed and adopted on a timely basis.

Effective Date

Date of enactment.

Subtitle D—Additional Consumer Protections

Sec. 131. Requiring Fair Marketing Practices by Health Insurers

Current Law

States have established fair marketing standards to regulate insurers' marketing activities.

Proposed Law

This provision would require the Commissioner to establish uniform marketing standards for QHBPs.

Reason for Change

This provision prohibits insurers from using unfair marketing practices as a mechanism to avoid risk and ensure that individuals and businesses are not misled by insurance companies when purchasing insurance.

Effective Date

January 1, 2013.

Sec. 132. Requiring Fair Grievance and Appeals Mechanisms

Current Law

ERISA does not require an employer to offer health benefits, but does mandate compliance to certain standards if an employer chooses to offer health benefits, such as procedures for appealing denied benefit claims. In addition, as of February 2008, 44 states and the District of Columbia mandate the independent review of benefit denials by an entity outside of the health plan ("external review").

Proposed Law

This provision would require QHBPs to provide for timely grievance and appeals mechanisms as established by the Commissioner. QHBPs would provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) promulgated by the Labor Department and published in the Code of Federal Regulations on November 21, 2000 (65 Fed. Reg. 70246). Such a process would be updated in accordance with any relevant standards that may be established by the Commissioner. The Commissioner would establish standards for an external review process (including expedited review of urgent claims), and any determination made with respect to a QHBP under an external review process would be binding. The requirements under this section would not affect the availability of judicial review under State law for adverse decisions under either the internal or external review process, subject to Section 151.

Reason for Change

To protect patients by ensuring a fair internal and external appeals processes in cases in which a patient needs to challenge a health plan's coverage denial or determination.

Effective Date

January 1, 2013.

Sec. 133. Requiring Information Transparency and Plan Disclosure

Current Law

ERISA requires applicable health plans (as well as other "welfare benefit" plans) to disclose and report certain plan information to enrollees and regulators. For example, plan administrators must provide to enrollees a written summary plan description (SPD) that contains the terms of the plan and the benefits offered, including any material modifications, and the SPD must be written in a manner that can be understood by the average enrollee. Certain plans must file an 24 annual report with the Department of Labor, containing information about the operation, funding, assets, and investments of those plans.

Proposed Law

This provision would require QHBPs to comply with disclosure standards established by the Commissioner concerning plan terms and conditions, claims payment policies, plan finances, claims denials, and other information as determined appropriate by the Commissioner. The Commissioner would require such disclosure to be provided in plain language. QHBPs would be required to comply with standards established by the Commissioner to ensure transparency regarding reimbursements between the plan and health care providers. A change in a QHBP could not be made without reasonable and timely advance notice to enrollees about the change.

Reason for Change

To ensure that enrollees and contracting health providers understand the terms and conditions of QHBP's and other health plans.

Effective Date

January 1, 2013.

Sec. 134. Application to Qualified Health Benefits Plans Not Offered Through the Health Insurance Exchange

Current Law

No Provision.

Proposed Law

The previous disclosure and other standards would apply to QHBPs offered outside of the Exchange only to the extent specified by the Commissioner.

Reason for Change

Provides the Commissioner with flexibility with regard to applying the provisions of this section to plans outside of the Exchange.

Effective Date

January 1, 2013.

Sec. 135. Timely Payment of Claims

Current Law

Under Medicare Advantage (MA), private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plans. MA plans include health maintenance organizations (HMO's) and private fee-for-service (PFFS) plans, among other plan types. MA PFFS plans that generally do not currently contract with providers are required to pay 95% of "clean claims" within 30 days of receipt. The Centers for Medicare and Medicaid Services (CMS) defines a clean claim as a claim that has no defect or impropriety, and is submitted with all the required documentation. The 30-day rule also applies to claims submitted to any MA organization by a provider who does not have a written contract with the plan. MA organizations are required to pay interest on clean claims that are not paid within 30 days. All other claims from non-contracted providers must be paid within 60 days. MA organizations that contract with providers (i.e., HMOs and PPOs) must include a prompt payment provision in their contracts.

Proposed Law

This provision would require QHBPs to comply with the prompt pay requirements applicable to Medicare Advantage plans.

Reason for Change

To ensure fair and timely payment for services rendered in the reformed health care system.

Effective Date

January 1, 2013.

Sec. 136. Standardized Rules for Coordination and Subrogation of Benefits

Current Law

While there are no federal statutes specifying primary and secondary payment rules for multiple insurers in the private market, Section 1862(b) of the Social Security Act authorizes the Medicare Secondary Payer (MSP) program, which identifies specific conditions under which another party pays first and Medicare is only responsible for qualified secondary payments. The statute authorizes several methods to identify cases when an insurer other than Medicare is the primary payer and to facilitate recoveries when incorrect Medicare payments have been made. Under certain conditions, the law makes Medicare the secondary payer to insurance plans and programs for beneficiaries covered through (1) a group health plan based on either their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program. Additionally, the Medicare statutes exclude Medicare coverage for items and services paid for directly or indirectly by a government entity, subject to certain limitations. This includes the Department of Veterans Affairs, among others.

Proposed Law

The Commissioner would establish standards for the coordination of benefits and reimbursement of payments in cases involving individual and multiple plan coverage.

Reason for Change

These changes are needed to enable effective coordination of varying health plans.

Effective Date

January 1, 2013.

Sec. 137. Application of Administrative Simplification

Current Law

To support the growth of electronic record keeping and claims processing, HIPAA's Administrative Simplification provisions instructed the Secretary to adopt electronic format and data standards for several routine administrative and financial transactions between health care providers and health plans/payers. The standards apply to health care providers (who transmit any health information in electronic form in connection with a HIPAA-specified transaction), health plans, and health care clearinghouses.

Proposed Law

This provision would require QHBP-offering entities (as defined in the bill) to comply with the new administrative simplification standards adopted under Sec. 163 (discussed below).

Reason for Change

These changes are needed to eliminate waste from today's health system and will provide savings for providers—ensuring a more efficient health care delivery system.

Effective Date

January 1, 2013.

Subtitle E—Governance

Sec. 141. Health Choices Administration; Health Choices Commissioner

Current Law

No provision.

Proposed Law

This provision would establish an independent agency in the Executive Branch of the United States called the Health Choices Administration ("Administration"). The Administration would be headed by a Health Choices Commissioner ("Commissioner"), who would be appointed by the President, with advice and consent of the Senate. Section 702 of the Social Security Act (detailing compensation, terms, general powers, rule-making, and delegation as applied to the Commissioner of Social Security and the Social Security Administration) would apply to the Commissioner.

Reason for Change

This Act brings significant new responsibilities to the government. In order to ensure these duties are carried out, a new agency is needed to coordinate the efforts.

Effective Date

Date of enactment.

Sec. 142. Duties and Authority of Commissioner

Current Law

No provision.

Proposed Law

This provision would make the Commissioner responsible for carrying out the following functions:

- *Qualified Plan Standards*—Establishing qualified health benefits plan ("QHBP") standards, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.
- *Health Insurance Exchange*—Establishing and operating the Health Insurance Exchange.
- *Individual Affordability Credits*—Administering individual affordability credits, including the determination of eligibility for such credits.
- *Promoting Accountability*—Undertaking activities in accordance with this section to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified

health benefit plans offered through or outside the Health Insurance Exchange.

• *Compliance Examination and Audits*—Coordinating with States to conduct audits of qualified health benefits plans compliance with federal requirements. These audits would include random compliance audits and targeted audits in response to complaints or other suspected non-compliance.

• *Recoupment of Costs in Connection with Examination and Audits*—Authorizing the Commissioner to recoup from qualified health benefits plans reimbursement for costs of such examinations and audit of such QHBP offering entities.

• *Data Collection*—Collecting data for the purposes of carrying out the Commissioner's duties, including promoting quality, value, protecting consumers and addressing disparities in health and health care; the commissioner may share such data with Secretary of Health and Human Services.

• *Sanctions Authority*—Providing any of the following remedies (in addition to any other authorized by law) in coordination with State insurance regulators and the Secretary of Labor if it is determined that a QHBP offering entity violates a requirement:

1. Civil money penalties of not more than the amount applicable under similar circumstances for similar violations under Medicare;

2. Suspension of plan enrollment of individuals under such plan after the date the Commissioner notifies the entity of a decision, until the Commissioner is satisfied with rectification;

3. In the case of an Exchange-participating health benefits plan, suspension of payment under the Health Insurance Exchange for individuals enrolled in the plan after the date the Commissioner notifies the entity of such decision and until the Commissioner is satisfied with corrective action; or

4. Work with State insurance regulators to terminate plans for repeated failure by the QHBP offering entity to meet this title's requirements.

• *Standard Definitions of Insurance and Medical Terms*—Providing the development of standards for defining terms used in health insurance coverage, including insurance-related terms.

• *Efficiency in Administration*—Issuing regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits including:

1. The determination of eligibility for affordability credits.

2. The use of personnel to carry out the duties of the Commissioner or in the case of sections 208 and 241(b)(2) of this Act, the use of State personnel in accordance with statutes.

Reason for Change

Authority needs to be granted to carry out the implementation of this Act. The Health Choices Commissioner is established to perform these functions as outlined above.

Effective Date

Date of enactment.

Sec. 143. Consultation and Coordination

Current Law

No provision.

Proposed Law

The Commissioner, as appropriate, would be required to consult with, at a minimum, the National Association of Insurance Commissioners (for purposes of using model guidelines), State attorneys general, and State insurance regulators concerning the standards and enforcement for insured qualified health benefits plans described in this title. Concurrently, the Commissioner would be required to consult with, at a minimum, Indian tribes and tribal organizations, appropriate federal agencies, and appropriate State agencies concerning affordability credits and the offering of Exchange-participating health benefits plans (including Medicaid concerning standards for insured qualified health benefit plans).

The Commissioner would be required to work in coordination with existing Federal and State entities to the maximum extent feasible and in a manner preventing conflicts of interests. Concurrently, the Commissioner would seek to achieve uniform standards that sufficiently protect consumers in a manner that does not unreasonably affect employers and insurers.

Reason for Change

Health care is regulated at the State and federal level and by a wide variety of agencies. To ensure effective implementation of the Act and uniform requirements across the country, it is important that all regulatory bodies coordinate efforts.

Effective Date

Date of enactment.

Sec. 144. Health Insurance Ombudsman

Current Law

The Department of Health and Human Services houses various complaint handling and client-assistance ombudsmen:

Food and Drug Administration (FDA) Ombudsman—Reviews marketing or investigational applications; provides information on import or export issues, ensures a fair hearing of claims of unfair or unequal treatment; also determines the jurisdiction of a product.

Long-Term Care Ombudsman—Mandated by Older Americans Act of 1965, consists of 1,000 paid and 14,000 volunteers who identify, investigate, and resolve complaints made by, or on the behalf, of residents. They have a blend of federal and state oversight.

Medicare Beneficiary Ombudsman—Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173), is intended to ensure those eligible for Medicare have reliable and current information about their benefits, rights and protections under the Medicare program, and the procedures for getting problems and disputes resolved. The Ombudsman is to aid Medicare recipients in filing appeals if their insurance did not pay proper amounts for their medical services or those services were denied.

Specialized Jurisdictional Ombudsmen—The FDA also has four additional ombudsmen who serve as the points of contact for specific public complaints connected to the subject of their jurisdiction. They are located at the Center for Biologics Evaluation and Research, Center for Drug Evaluation and Research, Center for Devices and Radiological Health, and Center for Veterinary Medicine. If any of the above cannot resolve or rectify a complaint, the issue is then sent to the FDA Office of Ombudsman.

In addition, several states (including VT, MN, and IL) have created State health insurance ombudsmen, with the core responsibilities of rectifying concerns encompassing access to care, billing problems, and access to health insurance. The Ombudsman provides information on state and federal programs that may be available, explains continuation rights under an existing health plan, provides help on how to shop for health insurance, and assists in appealing decisions made by their health insurance.

Proposed Law

The Commissioner would appoint within the Health Choices Administration a Qualified Health Benefits Ombudsman (with experience and expertise in the fields of health care and education). The Ombudsman would be required to perform the following duties:

• Receive and provide assistance with complaints, grievances, and requests for information submitted by individuals. The assistance would be provided more specifically in instances such as helping individuals determine relevant information for an appeal, assisting with any problems arising from disenrollment, choosing a qualified health benefits plan to enroll, and presenting information relevant to affordability credits.

• Submit annual reports to Congress and the Commissioner describing the activities of the Ombudsman, including recommendations for improvement in the Administration of this Division, as determined appropriate. The Ombudsman would not serve as an advocate for any increases in payments or new coverage of services, but would identify issues and problems in payment or coverage policies.

Reason for Change

Like the other ombudsman offices that have been established, this new ombudsman is created to protect consumers' interests and provide a consumer-oriented point of contact within the new agency.

Effective Date

Date of enactment.

Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 151. Relation to Other Requirements

Current Law

No provision.

Proposed Law

• *Coverage Not Offered Through the Exchange*—The requirements of this provision would not supersede specified federal and

state laws with respect to the health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan). Such laws encompass applicable requirements under the Public Health Service Act for certain group health plans and state and local employees requirements for health insurance coverage, group health plan standards and requirements under ERISA, or other applicable State laws. Nothing in this subsection would prevent application of State laws creating private rights of action with remedies or affect the application preemption (under Section 514 of ERISA).

• *Coverage Offered Through the Exchange*—The requirements under this title would not supersede any requirements relating to genetic information non-discrimination and mental health for such health insurance coverage (as long as those related do not prevent the application of requirements detailed in this division; as determined by the Commissioner). Concurrently, individual rights and remedies under State laws would apply. Nothing detailed in this paragraph would be construed as preventing the application of rights and remedies under State laws with respect to any referred requirement.

Reason for Change

This section clarifies the interaction between federal and state laws.

Effective Date

January 1, 2013.

Sec. 152. Prohibiting Discrimination in Health Care

Current Law

HIPAA established federal rules regarding non-discrimination based on health status-related factors. It prohibits group issuers from establishing rules for eligibility and premium contributions based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 (GINA, P.L. 110–233) prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information. The Mental Health Parity Act of 1996, as amended, establishes parity by prohibiting the placement of a dollar limit (either annual or aggregate lifetime) on mental health benefits that is less than such a limit for medical/surgical benefits for group health plans with more than 50 employees.

Proposed Law

Unless explicitly permitted within this Act and subsequent related regulations, all health care and related services (including insurance coverage and public health activities) covered by this Act would be provided regardless of personal characteristics extraneous to the provision of high quality health care or related services.

Within 18 months of enactment, the Secretary would be required to ensure that all health care and related services would be provided without regard for extraneous personal characteristics.

Reason for Change

Makes clear that civil rights protections are applicable to health insurance plans.

Effective Date

Within 18 months of enactment.

Sec. 153. Whistleblower Protection

Current Law

No provision.

Proposed Law

No employer may discharge any employee (or otherwise discriminate against) with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee):

- Provides or causes to provide to the employer, Federal Government, the attorney general of a relevant State, information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of any provision, order, rule, or regulation promulgated under this Act.
- Testifies or is about to testify in a proceeding concerning such violation.
- Assists, participates or is about to assist and participate in such a proceeding.
- Objects to, or refused to participate in any activity, policy, practice, or assigned task that the employee reasonably believes to be in violation of any provision, order, rule and regulation promulgated under this Act.

Enforcement Action—An employee covered by this section who alleges discrimination by an employer in violation may bring an action governed by the rules, procedures, legal burden of proof, and remedies detailed in section 40(b) of the Consumer Product Safety Act.

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

Rule of Construction—The rule of construction set forth concerning employee protections in the United States Code would apply to this section.

Reason for Change

To ensure the provision of quality, efficient health care, it is vital that health care workers be protected in instances where they con-

tribute to reporting of violations of this act. Otherwise, the fear of retaliation will discourage many to report such violations.

Effective Date

Date of enactment.

Sec. 154. Construction Regarding Collective Bargaining

Current Law

No provision.

Proposed Law

Nothing in this division would be construed to alter or supersede any statutory authority (or other obligation) to engage in collective bargaining over the terms and conditions of employment related to health care.

Reason for Change

Preserves collective bargaining rights.

Effective Date

Date of enactment.

Sec. 155. Severability

Current Law

No provision.

Proposed Law

If any provision of this Act, or the application thereof toward any person or circumstance, is held unconstitutional, the application of the remaining provisions would not be affected.

Reason for Change

To protect other sections of the act if any particular section is found unconstitutional.

Effective Date

Date of enactment.

Subtitle G—Early Investments

Sec. 161. Ensuring Value and Lower Premiums

Current Law

Medical loss ratio is the share of total premium revenue spent on medical claims. Medigap insurance policies are private supplemental health care policies that Medicare beneficiaries can purchase to help cover some items, services, and cost sharing not covered under Medicare. Medigap plans are required to have a minimum medical loss ratio of 65% for individual policies and 75% for group policies. In addition, some states impose medical loss ratios or related requirements on insurers in the individual and/or small group health insurance markets. As of June 2008, minimum ratios required by states ranged from 55% to 80%.

Proposed Law

Each health insurance issuer that offers health insurance coverage in the small or large group market would be required to provide rebates to enrollees if the coverage provided had a medical loss ratio below a level specified by the Secretary, for any plan year. The amount of the rebate would be sufficient to meet such loss ratio. The methodology would be set at the highest level medical loss ratio possible designed to ensure adequate participation by issuers, competition in the health insurance market, and value for consumer so that their premiums would be used for services. The Secretary would establish a uniform definition and a methodology for determining medical loss ratio, taking into account special circumstances of plans such as size, type, and longevity of the plan. These same provisions would also apply to health insurance coverage offered in the individual market.

Reason for Change

To ensure that plans are investing enrollee premiums in the provision of health benefits and not simply excessive administrative costs or profit.

Effective Date

These provisions would be effective for plan years beginning on or after January 1, 2011.

Sec. 162. Ending health insurance rescission abuse

Current Law

In the individual health insurance market, HIPAA guarantees renewal or continuation of individual health coverage at the option of the individual, except under specified circumstances. Those circumstances include nonpayment of premiums, fraud (including intentional misrepresentation of material fact) on the part of the enrollee, plan terminates coverage in the individual market, move of enrollee outside of the network service area, and enrollee membership in an association ends (in the case of association sponsored coverage). In addition, a handful of states prohibit issuers from rescinding or cancelling an enrollee's coverage in the individual market without prior review and approval from the state insurance department.

Proposed Law

This provision would clarify that the existing guaranteed renewability rules under HIPAA include prohibition of rescissions. An issuer would be allowed to rescind policies only upon clear and convincing evidence of fraud. No later than July 1, 2010, the Secretary would issue guidance on implementing this requirement. In order for a rescission to take effect, the issuer would be required to provide notice to the enrollee of the proposed rescission and give that enrollee the opportunity for a review of the determination by an independent, external third party under procedures specified by the Secretary. The health coverage for an enrollee who requests such a review would remain in effect until the third party determines such coverage may be rescinded under Secretarial guidance. The requirements related to external review would apply on and after

October 1, 2010 to all health insurance coverage, regardless of date of issue.

Reason for Change

This section curbs abuses by health insurers that retroactively deny patients their health coverage at the very time that coverage is most needed.

Effective Date

October 1, 2010.

Sec. 163. Administrative Simplification

Current Law

HIPAA's Administrative Simplification provisions required the Secretary to adopt electronic format and data standards for nine specified administrative and financial transactions, including those related to enrollment in a health plan, eligibility for a plan, and health care payment and remittance. In addition, HIPAA directed the Secretary to adopt a standard for transferring standard data elements among health plans for the coordination of benefits and the sequential processing of claims. In 2000, CMS issued an initial set of standards for seven of the nine specified transactions and for the coordination of benefits. As required under HIPAA, CMS published an updated version of the standards in early 2009. The compliance date for implementing those updated standards is January 1, 2012.

In September 2005, CMS published a proposed rule on a standard for electronic health care claims attachments, one of the two remaining transactions standards required to be adopted. A claims attachment transaction is used to request and supply additional data necessary to adjudicate a claim and typically includes specific clinical information that a plan needs in order to decide whether a service should be covered. This type of transaction is a key bridge between administrative transactions and clinical data. The claims attachment standard has yet to be finalized.

HIPAA's Administrative Simplification provisions also instructed the Secretary to develop security standards to safeguard electronic health information from unauthorized access, use, and disclosure, and to issue standards to protect the privacy of patient information. The HIPAA privacy rule, which took effect in 2003, established a set of patient rights, including the right of access to one's medical information, and placed certain limitations of when and how health plans and health care providers may use and disclose patient information. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted earlier this year as part of the Recovery Act, included a series of privacy and security provisions that amended and expanded the current HIPAA requirements. The HIPAA Administrative Simplification standards do not apply to the use and disclosure of information by financial institutions that are responsible for authorizing, processing, clearing, billing, transferring or collecting payments for premiums or health care.

Proposed Law

This provision would amend the HIPAA Administrative Simplification provisions by adding a new section requiring the Secretary, within two years of implementation of the updated HIPAA electronic transactions standards (i.e., by January 2014), to adopt an additional set of financial and administrative transactions standards to help clarify, complete, and expand the existing requirements. The goal would be for the standards to be unique (with no conflicting or redundant standards), authoritative, and comprehensive, requiring minimal augmentation by paper transactions. In addition, the standards would describe all data elements in unambiguous terms and not permit optional fields. They would enable real-time (or near real-time) determination of a patient's financial responsibility at the point of service and adjudication of claims, and harmonize all common data elements across transactions standards. Finally, the standards would have to support electronic funds transfers as well as timely and transparent claim and denial management processes, enable providers to quickly and efficiently enroll with a health plan so as to conduct other electronic transactions, and provide for other requirements related to administrative simplification as identified by the Secretary.

In developing the standards, the Secretary would be required to build upon existing and planned standards and regularly update the new standards. Within six months of enactment, the Secretary would be required to submit to Congress a plan for implementing and enforcing the new standards within five years of enactment. The plan would have to include a timetable for developing and regularly updating the new standards, implementation programs to help rural and other providers, an estimate of the funding needed to ensure timely completion of the implementation plan, and an enforcement process including timely investigation of complaints, random audits, and a fair and reasonable appeals process. The Secretary would have to ensure that all data collected pursuant to the new standards meets the HIPAA privacy and security requirements, as modified by the HITECH Act.

The provision would require the Secretary, within one year of enactment, to issue a final rule to establish a standard for health claims attachment transactions. It also would clarify that the HIPAA standards do not apply to the use and disclosure of information by financial institutions that process payments unless they are business associates of health plans and health care providers.

Reason for Change

These changes are needed to eliminate waste from today's health system and will provide savings for providers—ensuring a more efficient health care delivery system.

Effective Date

For subsection (a), regarding new HIPAA standards for electronic administrative and financial transactions, within five years of enactment. For subsection (b), new standards for claims attachments and coordination of benefits, adopted within one year of enactment, would apply to transactions occurring on or after six months after enactment.

Sec. 164. Reinsurance Program for Retirees

Current Law

No provision in current law. Average per capita health spending among the near elderly (55- to 64-year-olds) in 2004 was $7,787, or 50% more than spending among 45- to 54-year-olds ($5,210), and more than double that of 19- to 44-year olds ($3,370). These spending levels carry over into health insurance costs for these age groups. In the non-group market, average premiums for the near elderly were nearly $1,200 more than 45- to 54-year-olds and triple that for 25- to 34-year olds. The near elderly were more likely than their younger adult counterparts to spend more than 10% of their after-tax income on health care and health insurance premiums.

Proposed Law

No later than 90 days after enactment, the Secretary would establish a temporary reinsurance program, to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents, including eligible and surviving spouses. Health benefits would be required to include medical, surgical, hospital, prescription drug, and other benefits determined by the Secretary. An eligible employment-based plan would submit an application to the Secretary, as required. A participating employment-based program would submit claims for reimbursement to the Secretary, documenting the actual cost of items and services for each claim. Each claim would be based on the actual amount expended by the participant. The participating employment-based plan would take into account any negotiated price concessions, such as discounts, subsidies, and rebates. The cost of deductibles and cost-sharing would be included in the cost of the claim, along with the amounts paid by the plan. For any valid claim, the Secretary would reimburse the plan for 80% of the portion of costs above $15,000 and below $90,000. This amount would be adjusted annually based on the percent increase in the medical care component of the Consumer Price Index, rounded to the nearest multiple of $1,000. Amounts paid to a participating employment-based plan would be used to lower costs directly to participants and beneficiaries in the form of premiums, co-payments, deductibles, co-insurance, or other out-of-pocket costs, but would not be used to reduce the costs of an employer maintaining the employment-based plan. The Secretary would establish an appeals process for denied claims, procedures to protect against fraud, waste, and abuse, and would conduct annual audits of claims data.

The Retiree Reserve Trust Fund would be established consisting of such amounts as appropriated or credited to the Fund to enable the Secretary to carry out the reinsurance program. The Secretary could request such sums as necessary to carry out this section, not to exceed $10 billion. Amounts appropriated and outlays from such appropriation would not be taken into account for purpose of any budget enforcement procedures, thus exempting the Fund from the framework of the budget resolution and the points of order which enforce that framework. The Secretary would have the authority to stop taking applications or take other steps to reduce expenditures to ensure that expenditures did not exceed available funds.

Reason for Change

The provision of employer-sponsored retiree health benefits is of significant value to retirees. These investments also benefit the health system at large by keeping many of these individuals from otherwise becoming uninsured and resulting in higher uncompensated health care costs. This section provides financial assistance for those employers who continue to offer health benefits to their early retirees to encourage them to continue providing this valuable coverage.

The Committee intends to remove the language referring to an exemption from budget enforcement procedures prior to consideration by the House.

Effective Date

Not later than 90 days after enactment.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

Current Law

No provision.

Proposed Law

Sec. 201. Establishment of Health Insurance Exchange; Outline of Duties; Definitions

A Health Insurance Exchange ("Exchange") would be established to facilitate access of individuals and employers to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option. The Exchange would exist within the Health Choices Administration under the direction of the Health Choices Commissioner (described above in Sections 141 and 142). As described in greater detail in the following sections, regarding the Exchange, the Commissioner would (1) establish standards for, accept bids from, and negotiate and enter into contracts with entities seeking to offer qualified health benefits plans (QHBPs) through the Exchange, (2) facilitate outreach and enrollment of Exchange-eligible individuals and employers, and (3) conduct appropriate activities related to the Exchange, including establishment of a risk pooling mechanism and consumer protections.

Reason for Change

This provision would create a new, fair health insurance marketplace for individuals and families to choose from among a variety of plan options. The Commissioner of the Exchange will enforce federal minimum requirements for the individual and group market described in Title I. The Exchange would bring transparency to the health insurance marketplace so that individuals and families know what benefits their plan covers and what it will cost them.

Sec. 202. Exchange-eligible Individuals and Employers

Beginning in Y1, all individuals generally would be eligible to obtain coverage through the Exchange, unless they were enrolled in

the following (as determined by the Commissioner, in coordination with the Treasury Secretary):

- a group plan through a full-time employee (including a self-employed person with at least one employee) for which the employer makes an adequate contribution (described below in Section 312);
- Medicare;
- Medicaid (except in certain cases, discussed below); or
- Military and VA coverage.

Regarding Medicaid, individuals could still participate in the Exchange if their Medicaid eligibility was related to COBRA continuation coverage, tuberculosis, or breast or cervical cancer. As described in greater detail in Section 1701, Medicaid would be expanded to cover individuals up to 133% FPL who are not eligible under current state Medicaid programs—called "non-traditional Medicaid eligible individuals" per Section 205. A non-traditional Medicaid eligible individual could be Exchange-eligible if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the six months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual had chosen to enroll in an Exchange plan, the individual would be ineligible for regular Medicaid.

Except for the Medicaid exception described above, individuals would lose eligibility for Exchange coverage once they become eligible for Medicare Part A, Medicaid (although in this case, the Commissioner could permit continued Exchange eligibility for such limited time as the Commissioner determines it is administratively feasible and consistent with minimizing disruption in the individual's access to health care), and other circumstances as the Commissioner provides. Besides those cases, once individuals enroll in an Exchange plan, they would continue to be eligible until they are no longer enrolled.

Exchange-eligible employers could meet the requirements of the employer responsibility (Section 312) by offering and contributing adequately toward employees' enrollment through the Exchange. Those employees would be able to choose any of the available Exchange plans. Once employers are Exchange eligible and enroll their employees through the Exchange, they would continue to be Exchange eligible, unless they decided to then offer their own qualified health benefits plan(s).

In Y1, only employers with 10 or fewer employees would be Exchange-eligible. In Y2, employers with 20 or fewer employees would be Exchange-eligible. Beginning in Y3, the Commissioner could permit larger employers to participate in the Exchange. These additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate. ("Employer" and other employment-related definitions would be defined by the Commissioner.)

The Commissioner would have the authority to establish rules to deal with special situations with regard to uninsured individuals participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

The Commissioner would be required to provide for periodic surveys of Exchange-eligible individuals and employers concerning their satisfaction with the Exchange and its plans.

The Commissioner would conduct an Exchange Access Study—a study of access to the Health Insurance Exchange for individuals and for employers, including individuals such as Medicaid recipients and employers who are not eligible and enrolled in Exchange plans. The goal of the study would be to determine if there are significant groups and types of individuals and employers who are not Exchange eligible but who would have improved benefits and affordability if made eligible. The study also would examine the terms, conditions, and affordability of group health coverage offered by employers and QHBP-offering insurers outside of the Exchange compared to Exchange-participating health benefits plans, as well as the affordability test standard for access of certain employed individuals to coverage in the Health Insurance Exchange. The Commissioner would submit the study to Congress by January 1 of Y3, Y6 and thereafter, and would include in the report recommendations regarding changes in standards for Exchange eligibility for individuals and employers.

Reason for Change

This provision permits any individual or family to purchase a plan in the Exchange with their own funds if they are not enrolled in other coverage. This provision provides the Commissioner flexibility and discretion to make certain the Exchange operates effectively, including determinations of when certain sized employers could access the Exchange after the second year of operation. The Committee intends that the Commissioner open the Exchange to larger employers over time.

Sec. 203. Benefits Package Levels

The Commissioner would specify the benefits to be made available under Exchange plans during each plan year, consistent with this section and sections 121–134 above. The Commissioner could not enter into a contract with an entity wanting to offer coverage through the Exchange in a service area(s), unless the following requirements are met:

- The entity offers only one Basic plan in the service area.
- The entity may offer one Enhanced plan in the service area.
- If the entity offers an Enhanced plan in a service area, the entity may offer one Premium plan for the area.
- If the entity offers a Premium plan for a service area, the entity may offer one or more Premium-Plus plans for the area.

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

Consistent with the standards in Sections 101–164 above, the Commissioner would also establish the following standards for the three primary levels of Exchange plans—Basic, Enhanced, and Premium—and for additional benefits that may be offered in Premium-Plus plans. Besides offering the essential benefits package (Section 122 above) for a QHBP, Basic plan benefit packages would be modified to provide for reduced cost-sharing for individuals eligible for the "affordability cost-sharing credit," described below in Section 244. Excluding the credit, the benefit package of a Basic plan

would have an actuarial value representing payment for approximately 70% of all the covered items and services in the essential benefits package (Section 122 above). Enhanced plans would have lower cost-sharing than Basic plans, representing approximately 85% of the actuarial value of all the covered items and services in the essential benefits package. Premium plans would have lower cost-sharing than Enhanced plans, representing approximately 95% of the actuarial value of all the covered items and services in the essential benefits package. Premium-Plus plans would be Premium plans that also provide additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits would be separately specified.

The Commissioner would establish a permissible range of variation of cost-sharing for the Basic, Enhanced and Premium plans. Such variation would permit variations up to 10% in cost-sharing with respect to several benefit categories (Section 122); for example, with respect to a standard that provides for 20% coinsurance, the permissible variation would be between 18% and 22% coinsurance.

If a state requires health insurers to offer benefits beyond the essential benefits package, such requirements would continue to apply to Exchange plans, but only if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any resulting net increase in affordability premium credits (Section 243).

Reason for change

This provision establishes consistent benefit packages so that consumers can easily choose among plans and so that plans do not use differences in benefit packages as a way to avoid consumers with high health care risks.

Sec. 204. Contracts for the Offering of Exchange-participating Health Benefits Plans

The Commissioner would establish standards, described below, for Exchange-participating entities and their health benefits plans. The Commissioner would certify entities and plans if the 43 standards are met. The Commissioner would solicit and review bids from QHBP-offering entities for offering Exchange plans, negotiate with the entities, and enter into contracts with the entities for offering plans through the Exchange under terms negotiated between the Exchange and the entities.

The Federal Acquisition Regulation (the principal set of rules that govern the contracting process for the federal government) would not apply to contracts between the Commissioner and QHBP-offering entities for offering Exchange plans.

The standards for Exchange-participating entities would consist of the following requirements:

- The entity must be licensed to offer health insurance coverage under state law for each state in which it offers coverage.
- The entity must provide for reporting data/information specified by the Commissioner, including information necessary to administer the risk pooling mechanism in Section 206 and information to address disparities in health and health care.

• The entity must provide for implementation of the affordability credits provided for enrollees (described in Sections 241–246 below).

• The entity must accept all applicable enrollment via the Exchange, subject to such exceptions (such as capacity limitations) in accordance with the federal requirements for QHBPs (discussed under Title I), and would notify the Commissioner if it projects or anticipates reaching a capacity that would result in a limitation in enrollment.

• The entity must participate in the pooling mechanism as established by the Commissioner (described in Section 206 below).

• Regarding the Basic plan offered by the entity, the entity must contract for outpatient services with certain federally supported health care providers. The Commissioner would also specify how this requirement would apply to Health Maintenance Organizations (HMOs).

• The entity must provide culturally and linguistically appropriate communication and health services.

• The entity must comply with other applicable requirements of this title specified by the Commissioner, which would include standards regarding billing and collection practices for premiums and grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Exchange.

For the contracting process, entities' bids would have to contain the information required by the Commissioner. Contracts would last at least one year, but could be automatically renewed in the absence of notice of termination by either party. The contract would provide that if the Commissioner determines that a plan's provider network is not adequate, then the cost-sharing charged to a person who received out-of-network care would be the same as if the care had been provided in-network.

In coordination with state insurance regulators, the Commissioner would establish processes to oversee, monitor, and enforce applicable requirements on Exchange-participating entities and QHBPs, including plan marketing. In conjunction with state insurance regulators, the Commissioner would establish a process for individuals and employers to file complaints concerning violations. The Commissioner could terminate a contract with an entity if it fails to comply with the requirements of this title; the Commissioner could also impose one or more intermediate sanctions.

Any determination by the Commissioner to terminate a contract would be made in accordance with formal investigation and compliance procedures established by the Commissioner under which (a) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner's determination; and (b) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract. However, these procedures need not apply if the Commissioner determined that a delay in termination would pose an imminent and serious risk to the health of individuals enrolled under the plan.

Reason for change

To effectively operate an Exchange, the Commissioner will need to work with the States and establish the regulations needed to ensure plans offered in the Exchange meet federal requirements and certify that they meet the terms for operating in the Exchange.

Sec. 205. Outreach and Enrollment of Exchange-eligible Individuals and Employers in Exchange-participating Health Benefits Plan

Outreach. The Commissioner would conduct outreach activities to inform and educate individuals and employers about the Exchange and its participating health plans. Such outreach would include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments. The Commissioner's required outreach activities would include the following:

- broadly disseminate information on Exchange-participating plans, provided in a comparative manner and including information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction;
- provide assistance to Exchange-eligible individuals and employers via a toll-free telephone hotline and an Internet website;
- develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities;
- assist Exchange-eligible individuals in selecting plans and obtaining benefits; and
- ensure the information is developed using plain language (described in Section 133 above).

Enrollment. The Commissioner would be required to make timely determinations of whether individuals and employers are eligible for Exchange coverage and to establish and carry out an enrollment process, including at community locations. Enrollment would be permitted by mail, telephone, electronically, or in person.

Open enrollment for individuals and employers to enroll in an Exchange plan and affordability credits (described in Sections 241–245 below) would be at least 30 days and would be during September through November of each year before benefits would begin, or such other time that would maximize the timeliness of income verification. However, the Commissioner would also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who loses acceptable coverage, experiences a change in marital or other dependent status, moves outside the plan's service area, or experiences a significant change in income. The Commissioner, potentially with other appropriate entities, would be required to broadly disseminate information on the enrollment process, including before each enrollment period.

The Commissioner would establish a process to automatically enroll the following individuals into an appropriate Exchange plan (potentially involving a random assignment or some other form of assignment that takes into account the health care providers used by the individual, or such other relevant factors specified by the Commissioner):

- those who have applied for affordability credits, been determined eligible, have not opted out from receiving such credit, and do not enroll in another Exchange plan; and
- those enrolled in an Exchange plan that is terminated (during or at the end of a plan year) who do not enroll in another Exchange plan.

Under the enrollment process, individuals enrolled in an Exchange plan would pay such plans directly, not through the Commissioner or the Exchange.

Special provisions apply to newborns born in the United States without acceptable coverage at birth. Until other acceptable coverage begins, the child would be considered a non-traditional Medicaid-eligible individual (for whom the state would be paid 100% federal reimbursement) and would be deemed as having elected Medicaid coverage. This coverage would end no later than the end of the month 60 days after the child's birth; at the end of that period, if the child still does not have acceptable coverage, the child is deemed a traditional Medicaid-eligible individual, for whom the state receives the regular Medicaid federal matching rate.

As of the day before the first day of Yl, CHIP-eligible children, including targeted low-income children in a Medicaid-expansion CHIP program, would be deemed to be Exchange eligible.

The Commissioner would notify each state in Y1 whether the Exchange could support enrollment of these children.

A "traditional Medicaid eligible individual" is a Medicaid-eligible individual excluding (1) those who are eligible because of the expansion of Medicaid in Section 1701 of this legislation to individuals up to 133% FPL and (2) a childless adult who would not otherwise be classified as categorically needy (as per current Medicaid statute, Section 1902(a)(10)(A)) or medically needy (as per current Medicaid statute, Section 1902(a)(10)(C)) as in effect as of the day before the date of enactment of this Act. A "non-traditional Medicaid-eligible individual" is a Medicaid-eligible individual who is not a traditional Medicaid-eligible individual. Section 202 of the legislation includes provisions so that a non-traditional Medicaid eligible individual could be Exchange-eligible if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the six months before the individual became a non-traditional Medicaid eligible individual. Under this section, the Commissioner would provide these individuals with the option to enroll in Medicaid rather than an Exchange plan and to change that election during open enrollment periods described earlier in this section.

An Exchange-eligible individual could apply for a Medicaid-eligibility determination. If the individual is determined to be eligible, the Commissioner would provide for the individual's enrollment under the state Medicaid plan in accordance with the Medicaid memorandum of understanding. In the case of such an enrollment, the state would provide for the same periodic redetermination of eligibility under Medicaid that would apply if the individual had directly applied to the state Medicaid agency. The legislation would require the Commissioner, in consultation with the HHS Secretary, to enter into a memorandum of understanding with each state with respect to coordinating enrollment of individuals in Exchange plans and under state Medicaid programs, and to otherwise coordinate

the implementation of these provisions with respect to the Medicaid program. This memorandum would permit the exchange of information consistent with limitations specified in Medicaid statute with respect to providing safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the state Medicaid plan, and at state option, the exchange of information necessary to verify eligibility for other federal programs (e.g., for free and reduced price school lunches). None of these provisions could be construed as permitting such memorandum to modify or vitiate any requirement of a state Medicaid plan.

In carrying out this section, the Commissioner would establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

Reason for Change

To ensure that individuals and families are well aware of their rights and responsibilities under the act, the Commissioner must establish procedures to educate and enroll individuals and families.

Sec. 206. Other Functions

The Commissioner would be required to coordinate the distribution of affordability premium and cost-sharing credits (described below in Sections 243–244) to the Exchange plans. The Commissioner would also be required to establish a risk-pooling mechanism, to adjust premium payments to Exchange plans to take into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the Exchange plans.

An Office of the Special Inspector General for the Exchange would be established, headed by a Special Inspector General appointed by the President and confirmed by the Senate. The Special Inspector General's nomination would be made as soon as practicable after the establishment of the Exchange.

The duties of the Special Inspector General would consist of the following:

- conduct, supervise, and coordinate audits, evaluations and investigations of the Health Insurance Exchange to protect the integrity of the Exchange as well as the health and welfare of participants in the Exchange;
- report both to the Commissioner and to the Congress regarding program and management problems and recommendations to correct them;
- related to the duties above, have other duties described as applying to the Special Inspector General of the Troubled Asset Relief Program (TARP), per paragraphs (2) and (3) of Section 121 of P.L. 110–343; and
- in carrying out these duties, have the authorities of inspectors general in Section 6 of the Inspector General Act of 1978.

Other provisions of the TARP Special Inspector General would also be applied, regarding the basis of the Special Inspector General's appointment, how s/he might be removed, his/her salary, and available personnel, facilities and other resources.

Not later than one year after the confirmation of the Special Inspector General, and annually thereafter, the Special Inspector

General would submit to the appropriate committees of Congress a report summarizing the activities of the Special Inspector General during the one year period ending on the date the report is submitted.

The Office of the Special Inspector General would terminate five years after the date of the enactment of this Act.

Reason for Change

This provision ensures the Commissioner has full authority to operate the Exchange and creates an Inspector General to ensure adequate oversight and to combat waste, fraud and abuse within the system.

Sec. 207. Health Insurance Exchange Trust Fund

A "Health Insurance Exchange Trust Fund" would be created within the U.S. Treasury, consisting of such amounts as may be appropriated or credited to the fund. The Commissioner would pay from the Trust Fund amounts as determined necessary to make payments to operate the Exchange, including affordability credits.

Dedicated payments to the Trust Fund would include the following:

- taxes on individuals not obtaining acceptable coverage (Section 401);
- taxes on employers electing to not provide health benefits (Section 412); and
- excise tax on employers who fail to satisfy health coverage participation requirements (Section 411).

Such additional sums as necessary would be appropriated. General provisions in the Internal Revenue Code regarding federal government trust funds would apply.

Reason for change

A trust fund is needed to hold the taxes collected under this act and to enable the payment from that fund for affordability credits and other costs of the Exchange.

Sec. 208. Optional Operation of State-based Health Insurance Exchanges

If a state (or group of states, subject to the Commissioner's approval) applied to the Commissioner for approval of a state-based Health Insurance Exchange, and if the Commissioner approves such state-based Exchange, then the state-based Exchange would operate instead of the federal Exchange in that state(s).

The Commissioner could not approve a state-based Exchange unless the following requirements were met (and would be required to approve it if the conditions were met):

- The state-based Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that it could carry out the functions specified for the federal Exchange in the state(s) including:
  - negotiating and contracting with qualified plans;
  - enrolling Exchange-eligible individuals and employers in plans;
  - establishing sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

○ administering premium and cost-sharing credits (described below in Sections 241–246) using the same methodologies, and at least the same income verification methods, as would otherwise apply and at a cost to the federal government that is not greater than what would otherwise apply; and

○ enforcement activities consistent with federal requirements.

• There is no more than one Exchange in operation in any one state.

• The state provides assurances satisfactory to the Commissioner that approval of such an Exchange would not result in any net increase in expenditures to the federal government.

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

• Such other requirements as the Commissioner may specify.

A state-based Exchange could, at the option of the state, and only after providing timely and reasonable notice to the Commissioner, cease operation. In this case, the federal Exchange would be operational in the state(s).

The Commissioner could terminate the approval (for some or all functions) of a state-based Exchange if the Commissioner determined that it no longer met the requirements listed above or was no longer capable of carrying out such functions. In lieu of terminating the state-based Exchange's approval, the Commissioner could temporarily assume some or all functions of the state-based Exchange until the Commissioner determined that it met the applicable requirements and was capable of carrying out those functions. The ceasing or termination of a state-based Exchange would be effective in such time and manner as the Commissioner would specify.

Enforcement authorities of the Commissioner would be retained by the Commissioner. The Commissioner could specify functions of the federal Exchange that may not be performed by a state-based Exchange or that could be performed by both the Commissioner and the state-based Exchange.

In the case of a state-based Exchange, except as the Commissioner may otherwise specify, any references to the "Exchange" or to the "Commissioner" in the area in which the state-based Exchange operates would be deemed a reference to the state-based Exchange and the head of that Exchange.

In the case of a state-based Exchange, funding assistance would be provided for its operation in the form of a matching grant, with a state share of expenditures required.

Reason for Change

Ensures that States have the flexibility to choose to operate their own exchanges in lieu of the national Exchange. It also ensures that federally mandated minimum requirements are established and enforced across the nation and that states must meet federally mandated minimum requirements, but nothing in this title prevents a state from setting standards above the federal requirements.

Effective Date

January 1, 2013 for sections 201–208.

Subtitle B—Public Health Insurance Option

Sec. 221. Establishment and Administration of a Public Health Insurance Option As An Exchange-Qualified Health Benefits Plan

Current Law

There is no federal public health insurance option that is currently available for the non-disabled population under age 65. Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program including eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost-sharing amounts.

Proposed Law

The provision would require the Secretary of Health and Human Services (Secretary) to provide for the offering of a public health insurance option through the Exchange starting Y1. The Secretary would be required to ensure that the public option provided choice, competition and stability of affordable, high quality coverage throughout the United States. The Secretary's primary responsibility would be to create a low-cost plan without compromising quality or access to care.

The public option would only be available through the Health Insurance Exchange. The public option would be required to comply with requirements applicable to Exchange-participating health benefit plans, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing. The public option would be required to offer basic, enhanced, and premium plans, and would be allowed to offer premium-plus plans.

The Secretary would be allowed to enter into contracts for the administration of the public option in the same manner as the Secretary is allowed to enter into contracts for the administration of the Medicare program. These administrative functions include, subject to restrictions, determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance. The provision would prohibit contracts that involve the transfer of insurance risk.

The Secretary would be required to establish an office of the ombudsman for the public health insurance option which would have duties similar to those of the Medicare Beneficiary Ombudsman.

The Secretary would be required to collect data necessary to establish premiums and payment rates and for other purposes, including improving quality and reducing racial and ethnic disparities in health and health care.

With respect to the public health insurance option, the Secretary would be treated as an entity offering a Quality Health Benefit Plan through the Exchange.

The provisions relating to access to Federal courts for enforcement of rights under Medicare would apply to the public option and individuals enrolled under the public option in the same manner that they apply to Medicare and Medicare beneficiaries.

Reason for Change

Many parts of the country have no effective competition in the insurance market. Health reform won't change that on its own. Only the creation of a national public health insurance option would ensure that all communities have access to a choice of health plans.

In addition to expanding choice, a public health insurance option would inject price competition into the marketplace. Because the public option would not need to return profits to shareholders or pay exorbitant CEO salaries, the Congressional Budget Office estimates that it would be able to offer premiums slightly lower than private insurers do today. By injecting a lower price point into the market and providing more choice for people, the public option would force private insurers to seek efficiencies so they could lower their prices and improve their customer service to effectively compete.

For health reform to prove effective, it must also change the way health care is delivered in our country—promoting primary care, encouraging coordinated care, and improving quality. The public health insurance option will be able to institute new payment structures and incentives to promote these critical reforms. As our experience with Medicare has shown, such innovations will expand access across the health care system as private plans adopt features that benefit their bottom lines. This will help cut costs across the system.

In sum, the public health insurance option would expand choice, lower cost, and enhance innovation—all key components of health reform.

Effective Date

January 1, 2013.

Sec. 222. Premiums and Financing

Current Law

No provision.

Proposed Law

The Secretary would be required to establish geographically-adjusted premiums for the public option in a manner that complies with the premium rules established by the Commissioner for Exchange-participating health benefit plans and at a level sufficient to fully finance the cost of health benefits and administration for the public option. Premiums would be required to include an appropriate amount for a contingency margin.

The provision would establish an account in the Treasury for receipts and disbursements attributable to the public option, including start-up funding. The start-up funding would be equal to the sum of $2 billion for the establishment of the public option, and such sums as may be necessary to cover 90 days worth of reserves

based on projected enrollment. These amounts would be authorized to be appropriated to the Secretary out of any funds in the Treasury not otherwise appropriated. The Secretary would be required to provide for repayment of the startup funding in an amortized manner over a 10-year period starting in Y1. The provision specifies that nothing in this section could be construed as authorizing any additional appropriations to the account, other than amounts otherwise provided with respect to other Exchange-participating plans. As under the Medicare Advantage program, states would be prohibited from imposing a premium tax or similar tax with respect to the public option.

Reason for Change

This provision makes clear that HHS will have to determine premiums for the public option in each region similar to other plans in the Exchange. To ensure a level playing field with private plans, HHS will have to include initial start-up costs; however, the public option will be required to repay these initial funds in full. Beyond the initial appropriation (which will be repaid), the public option will finance costs for medical benefits and administration through its premiums.

Effective Date

January 1, 2013.

Sec. 223. Payment Rates for Items and Services

Current Law

No provision.

Proposed Law

The Secretary would be required to establish payment rates for services and health care providers under the public option, and would have the authority to change payment rates in accordance with reforms under Section 224 as described below.

In general, during the first three years of the public option, the Secretary would be required to base payment rates on the rates for similar services and providers under Medicare. Several exceptions to this provision would apply. First, payments for physicians' services otherwise established under Medicare would be applied to the public option without regard to the sustainable growth rate—one component of the formula used to update Medicare payments for physicians' services. Second, the update factor for physicians' payments for a year under the public option would not be less than 1%. Third, the Secretary would be given the authority to determine the extent to which adjustments applicable to the base payment rates under Part A and B of Medicare would apply to the public option. The Secretary would be required to modify the payments based on Medicare to accommodate payments for services not otherwise covered under Medicare, such as well-child visits. Under the public option, payments for prescription drugs that are not covered under Medicare Part A or B would be based on rates negotiated by the Secretary. As introduced and reported, H.R. 3200 would allow the Secretary discretion to establish a prescription drug formulary, and use other methods, including those used by private sector

pharmacy benefit managers, to reduce prescription drug costs under the public health insurance option, and the Committee expects that the Secretary would implement such a formulary.

For services furnished in Y1, Y2, and Y3 of the public option, physicians and other health care practitioners who participate in both Medicare and the public option would receive payment rates 5% greater than rates otherwise established by the Secretary for items and professional services. Pediatricians and other practitioners who do not typically participate in Medicare—as determined by the Secretary—would also be eligible for the increased payment rates. Beginning in Y4 of the public option, the Secretary would be required to continue to use an administrative process to set payment rates to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of health care. The Secretary would be prohibited from setting rates at levels expected to increase overall medical costs for the public option beyond what would be expected if Medicare rates (plus the 5% addition) were to continue.

Medicare participating providers would be participating providers under the public option unless they opted out in a process established by the Secretary.

Chapter 5 of title 5 of the United States Code, dealing with administrative procedures in . government organizations, would apply to the process for initially establishing payment rates for the public option, but not to the specific methodology or calculation of those rates. Nothing in this section would limit the Secretary's authority to correct payments that were excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating plans. Nothing in this section would affect the Secretary's authority to establish payment rates, including payments to providers for more efficient delivery of services, such as the initiatives under Section 244 of this bill, as described below. The provision would prohibit administrative or judicial review of a payment or methodology established under this section, or Section 244 on modernized payment initiatives and delivery system reform.

Reason for Change

Outlines payment rates for the public option providers and provides the Secretary more with considerably more flexibility than current law Medicare to establish rates in the public option. Ensures that provider participation in the public option is voluntary.

Effective Date

January 1, 2013.

Sec. 224. Modernized Payment Initiatives and Delivery System Reform

Current Law

No provision.

Proposed Law

Beginning in the first year of the public option, the Secretary would be given the authority to use innovative payment mecha-

nisms and policies to determine payments for items and services under the public option. The payment mechanisms and policies may include the following: patient-centered medical home, other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. The Secretary would be required to design and implement the payment mechanisms and policies in a way that promotes high-quality care that is integrated, patient-centered and efficient, and that seeks to either (a) improve health outcomes, (b) reduce health disparities, (c) address geographic variation in the provision of health services, (d) prevent or manage chronic illness, or (e) provide efficient and affordable care. To the extent allowed under the rules for Exchange-participating plans, the provision would allow cost-sharing and payment rates under the public option to be modified to encourage the use of services that promote health and value. The provision specifies that nothing in the subtitle would prevent the Secretary from varying payments based on different payment structure models for different geographic areas.

Reason for Change

Provides the Secretary of HHS with broad authority to implement payment reforms to improve the delivery of health care and encourages the Secretary to build on efforts begun in Medicare.

Effective Date

January 1, 2013.

Sec. 225. Provider Participation

Current Law

No provision.

Proposed Law

The Secretary would be required to establish conditions of participation for health care providers under the public option. The Secretary would be prohibited from allowing a health care provider to participate unless appropriately licensed or certified under State law. A health care provider that was excluded from participation in a Federal health care program (as defined in Section 1128(f) of the Social Security Act), would be prohibited from participating under the public option.

Annually, the Secretary would be required to provide for physicians to participate in the public plan in one of two classes: (a) preferred physician, or (b) participating non-preferred physician. A preferred physician would be one who agreed to accept the established rate as payment in full. A participating non-preferred physician would be one who could impose charges that exceed the charges that may be imposed for such items and services in relation to the payment rate for such items and services under the public option (i.e. to "balance bill"). The participating non-preferred physician would agree not to impose charges that exceed 115% of the amount established under Sec. 223 (consisting of the Medicare rate and the 5% addition). The Secretary would be required to pro-

vide for the participation of non-physician providers. Non-physician providers would only be allowed to participate if they accepted the established rates as payment in full.

Reason for Change

This provision ensures that the Secretary has the tools to establish the terms and conditions for providers to participate in the public option. The provision also defines two levels of physician participation and, in order to protect consumers, establishes rules on permissible cost sharing and payment to non-participating providers who treat enrollees in the public option.

Effective Date

January 1, 2013.

Sec. 226. Application of Fraud and Abuse Provisions

Current Law

Title XVIII of the SSA, the Medicare statutes, requires activities that prevent, detect, investigate and prosecute health care fraud and abuse. In general, initiatives designed to fight fraud, waste, and abuse are considered program integrity activities. Program integrity is considered a component of the effective and efficient administration of government programs, which are entrusted with ensuring that taxpayer dollars are spent wisely. Efforts to ensure Medicare program integrity encompass a wide range of activities and require coordination among multiple private and public entities. This includes processes directed at reducing payment errors to Medicare providers, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse.

Proposed Law

The provisions of law (other than criminal law) identified by the Secretary by regulation, in consultation with the Inspector General, that impose sanctions with respect to waste, fraud, and abuse under Medicare would also apply to the public health insurance option.

Reason for Change

Applies Medicare waste, fraud and abuse requirements in a similar manner to the public option.

Effective Date

January 1, 2013.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability Through Health Insurance Exchange

Current Law

No provision.

Proposed Law

This provision would provide premium and cost-sharing credits to "affordable credit eligible individuals" (defined in Section 242) for certain individuals enrolled in coverage through the Exchange.

The Commissioner would pay each QHBP participating in the Exchange the aggregate amount of credits for all eligible individuals enrolled in that plan.

An Exchange-eligible individual could apply to the Commissioner, through the Exchange or another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner, through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner, would make a determination as to eligibility of an individual for affordability credits. The Commissioner would establish a process whereby, on the basis of information otherwise available, individuals may be deemed eligible for credits. The Commissioner would also establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

If the Commissioner determines that a state Medicaid agency has the capacity to make a determination of eligibility for affordability credits under the same standards as used by the Commissioner under the Medicaid memorandum of understanding (described above in Section 205), the state Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination, and the Commissioner would reimburse the state Medicaid agency for the costs of conducting such determinations.

In addition, there would be a Medicaid screen-and-enroll obligation, which would ensure that individuals applying for affordability credits, may be screened for Medicaid eligibility. If they are determined eligible for Medicaid, the Commissioner, through the Medicaid memorandum of understanding, would provide for their enrollment under the state Medicaid plan, and the state would provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply.

During the first two years of implementation, credits would be allowed for coverage under a Basic plan only. Beginning in the third year, credits would be allowed for coverage under Enhanced or Premium plans by a process established by the Commissioner. Credits would continue to be based on the basic plan, the individual would be responsible for any difference between the premium for an Enhanced or Premium plan and the credit amount based on a Basic plan applicable to that enrollee.

The Commissioner would be authorized to request from the Treasury Secretary information that may be required to carry out this subtitle (regarding individual affordability credits), consistent with existing rules regarding confidentiality and disclosure of tax return information. Individuals who are eligible to receive credits would not receive them in the form of cash payments.

Reason for Change

Establishes affordability credits for those without other coverage—or an offer of affordable coverage—to assist individuals and families with the purchase of health insurance coverage. These credits are key to ensuring people affordable health coverage. It also provides for the Exchange to coordinate with state Medicaid programs to ensure people are enrolled in the appropriate program.

Effective Date

January 1, 2013.

Sec. 242. Affordable Credit Eligible Individual

Current Law

No provision.

Proposed Law

This provision would define an "affordable credit eligible individual" as an individual who (1) is lawfully present in a state in the United States (other than a nonimmigrant, with some exceptions), (2) is enrolled in an Exchange plan and is not enrolled through an employer plan that meets the employer responsibility to contribute toward employee and dependent coverage (described below in Section 312), (3) has family income below 400% FPL, and (4) who is not a Medicaid-eligible individual (other than some exceptions described above in Section 202). Family members who are eligible for credits will be treated as a single affordable credit eligible individual.

Credits would not be available to full-time employees of an employer offering coverage consistent with the employer contribution rules described in Section 312. The Commissioner would make exceptions to this rule for divorced or separated individuals, or dependents of employees who would otherwise be eligible for credits. Exceptions would also be made, beginning in Y2, for full-time employees whose premium costs under a group health plan exceed 11% of family income.

Income would be defined as "modified adjusted gross income" (MAGI), per the new section 59B of the Internal Revenue Code, added in Sec. 401. The Commissioner would conduct a study to examine the application of income disregards for the purposes of the affordability credits. The Commissioner would submit a report to Congress of such a study, including recommendations as the Commissioner determines appropriate. Affordability credits would not be treated as a federal means-tested public benefit for eligibility purposes for qualified aliens under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Reason for Change

This provision establishes that only American citizens and legal immigrants without an affordable offer of coverage (defined as premiums above 11 percent of family income) can apply for and receive credits toward health insurance coverage in the Exchange. The credits are focused on families most in need of assistance with the cost of health insurance coverage and are designed to assure that people obtain needed health care at an affordable price.

Effective Date

January 1, 2013.

Sec. 243. Affordable Premium Credit

Current Law

No provision.

Proposed Law

This section would establish the rules for determining the amount of the premium credit provided to eligible individuals enrolled in an Exchange plan. The "affordability premium credit" would be an amount equal to the lesser of (1) the amount by which the enrollee's premium exceeds a specified level that is considered affordable ("affordable premium amount"), or (2) the amount by which the "reference premium" (the average premium of the three least expensive Basic plans in the individual's premium rating area) exceeds the "affordable premium amount." In calculating the reference premium, the Commissioner may exclude plans with extremely limited enrollments to ensure a more representative calculation.

The affordable premium credit amount would be calculated on a monthly basis, based on the following table, to limit individuals' premium payments to a percentage of family income (MAGI) relative to the poverty level, as specified in the table below.

Federal poverty level (FPL) (in percent)	Premium payment limit, as a percent of income
133 or less	1.5
150	3
200	5
250	7
300	9
350	10
400	11

The Commissioner would establish premium percentage limits so whose family income is between the income tiers specified in the table, the percentage limits would increase on a linear sliding scale.

Reason for Change

Establishes the limits on premiums for individuals and families who are eligible for affordability credits. These limitations help ensure affordable health premiums for people below 400% of federal poverty who are buying coverage through the Exchange.

Effective Date

January 1, 2013

Sec. 244. Affordability Cost-Sharing Credit.

Current Law

No provision.

Proposed Law

The affordability cost-sharing credit under this section would be available to those enrolled in an Exchange plan whose income is less than 400% FPL. The Commissioner would specify reductions in cost-sharing amounts and the annual limitation (out-of-pocket maximum) on cost-sharing under a Basic plan so that the average percentage of covered benefits paid by the plan (as estimated by the Commissioner) is equal to the percentages (actuarial values) in the table for each income tier.

Federal poverty level (FPL) (in percent)	Actuarial value percentage
150 or less	97
200	93
250	85
300	78
350	72
400	70

The Commissioner would provide payments to QHBP-offering entities in an amount equivalent to the increased actuarial value of benefits resulting from the cost-sharing reductions.

Reason for Change

Establishes cost sharing limitations for individuals and families who are eligible for affordability credits. These limitations help ensure affordable cost-sharing and access for people below 400% of federal poverty who are buying coverage through the Exchange.

Effective Date

January 1, 2013.

Sec. 245 Income Determinations

Current Law

No provision.

Proposed Law

This provision would use an individual's adjusted gross income in the most recent taxable year for determination of a credit under this Subtitle. The Commissioner would take steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle. The Commissioner would request information from the Treasury Secretary as may be permitted to verify income information submitted in applications for credits. The Commissioner would establish procedures for verification of income if no tax return is available for the most recent completed tax year. The Commissioner would establish special rules for cases when an individual's income is expected (in a manner specified by the Commissioner) to be significantly different from the income submitted for application for and determination of a credit. The Commissioner would establish rules under which an individual would be required to inform the Commissioner when there is a significant change in income. Such mechanism would provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the family income of the individual, the Commissioner would provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

For a CHIP-eligible child deemed to be eligible for coverage through the Exchange, during the first year of implementation the Commissioner would establish rules under which family income of the child is deemed to be no greater than the family income of that child as most recently determined by the State under CHIP. The Commissioner would examine the feasibility and implication of ad-

justing the application of the federal poverty level in this Subtitle to take into account geographic differences, in order to reflect cost-of-living variations across the country. The Commissioner would submit a report to Congress, no later than the first day of the second year of implementation, on such a study and make recommendations as appropriate. An individual who intentionally misrepresents family income or fails to disclose to the Commissioner a significant change in family income would be liable for repayment of any improperly received credit and, in the case of intentional misrepresentation, may be required to pay an additional penalty as imposed by the Commissioner.

Reason for change

Establishes the process for the Commissioner to determine income eligibility for affordability credits and directs the Commissioner to establish clear, enforceable procedures for eligibility determinations so that financial assistance is provided as outlined in this act.

Effective Date

January 1, 2013.

Sec. 246. No Federal Payment for Undocumented Aliens

Current Law

No provision.

Proposed Law

No credits would be given to individuals who are not lawfully present in the country.

Reason for change

The provision reinforces that credits are not available for undocumented persons and that the Commissioner will have to establish a process to enforce this federal requirement.

Effective Date

January 1, 2013.

TITLE III—SHARED RESPONSIBILITY

A. Individual Responsibility (sec. 301 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

Individual responsibility is a key component of health reform. In order to control rising health care costs, it is vital that everyone be part of the health care system. The only way to ensure that almost everyone is participating is to require such participation by law. To that end, the bill institutes a tax on individuals who choose not to purchase qualified health insurance as the mechanism to enforce participation. The Committee believes that a fair tax rate is based

on the individual's ability to pay, but capped at the average cost of health insurance in the national market.

EXPLANATION OF PROVISION

The provision cross-references the shared responsibility provisions of section 59B of the Code (as added by section 401 of the bill) which provides for a tax on an individual (or a husband and wife in the case of a joint return) who do not maintain coverage under acceptable health insurance for themselves and each of their qualifying children.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2012.

B. Health Coverage Participation Requirements (sec. 311 of the bill)

PRESENT LAW

For employers that currently choose to provide health coverage for their employees, the cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[1] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[2]

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-provided health coverage under an accident or health plan.[3] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from the gross income of the employee.[4] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pretax basis through salary reduction.[5] Such salary reduction contributions are treated as employer contributions and thus are also excluded from gross income.

The Employee Retirement Income Security Act of 1974 ("ERISA")[6] preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance with certain rules if an employer

[1] Sec. 162. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.
[2] Secs. 3121(a)(2) and 3306(b)(2).
[3] Sec. 106.
[4] Sec. 105(b).
[5] Sec. 125.
[6] Pub.L. No. 93–406.

chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act[7] and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")[8] and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[9] adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to $100 per day per failure during the period of noncompliance and generally is imposed on the employer sponsoring the plan.[10]

Under Medicaid, states may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his or her employer, the coverage must be comprehensive and cost-effective for the State. A 2007 analysis showed that 12 states had Medicaid premium assistance programs as authorized under current law.[11]

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility to ensure that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to either offer coverage to their employees or contribute to the cost of health care coverage, and that the most effective means of implementing health care reform is to build on the current system of employer-sponsored health coverage that already provides coverage to many American families.

EXPLANATION OF PROVISION

Employers offering health benefit plans are required to offer individual and family coverage under a qualified health benefits plan[12] (or under certain grandfathered plans) and to make contributions to help discharge the coverage costs of employees enrolled in the employer-provided plan.

Beginning in the second year after the general effective date of the market reforms of the bill, employers are required to make contributions to the Health Insurance Exchange (the "Exchange") for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. However contributions are

[7] 42 U.S.C. GA.
[8] Pub. L. No. 99–272.
[9] Pub. L. No. 104–191.
[10] Secs. 4980B and 4980D.
[11] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, "The State Children's Health Insurance Program," Powerpoint Presentation, March 5, 2007, p. 14.
[12] For a plan to be a "qualified health benefits plan" it needs to meet certain minimum coverage requirements, but it need not be offered through the Exchange.

not required if the employee declines coverage because the employee is enrolled in family coverage in the Exchange as a spouse or dependent of another insured.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

C. Employer Responsibility to Contribute Towards Employee and Dependant Coverage (sec. 312 of the bill)

PRESENT LAW

For employers who choose to offer coverage to their employees, the cost to an employer of providing health coverage for its employees, including the cost of employer contributions towards health coverage premiums, is generally deductible as an ordinary and necessary business expense for employee compensation.[13] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[14]

REASONS FOR CHANGE

The Committee believes that employers have a particular responsibility to contribute to the cost of health care of their employees, and this requires substantive contributions to single or family health plans provided by the employer. These employer contributions will help in the effort to provide quality, affordable health coverage for all Americans.

EXPLANATION OF PROVISION

Contribution requirements

Employers that offer health benefit plans are required to offer individual and family coverage under a qualified health benefit plan[15] (or certain grandfathered health insurance plans) and to make contributions to help discharge the coverage costs of employees (and their spouses and qualifying children, if any) enrolled in the employer-provided plan.

For full time employees, the contribution amount is required to be at least 72.5 percent of the lowest cost plan offered by the employer which meets the requirements of the essential benefits package[16] (65 percent for eligible employees electing family coverage).[17] For part time employees, the contribution amount is a fraction (as determined in accordance with rules of the Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury, as applicable) of the minimum contributions

[13] Sec. 162. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

[14] Secs. 3121(a)(2) and 3306(b)(2).

[15] For a plan to be a "qualified health benefits plan" it needs to meet certain minimum coverage requirements, but it need not be offered through the Health Insurance Exchange.

[16] The essential benefits package includes certain specified limits on required cost sharing, bans annual or life time limits on covered health care items or services and certain specified minimum services, and imposes certain requirements as to network adequacy as determined by the Health Choices Commissioner.

[17] There is a special rule for determining the lowest cost plan with respect to coverage of an employee under an Exchange participating health benefits plan. In that case the lowest cost plan is the reference premium used for determining the amount of affordability credits.

made for full time employees, with such fraction being equal to a ratio of the average weekly hours worked by the employee compared to the minimum weekly hours specified by the Health Choices Commissioner. An employer cannot satisfy the minimum contribution requirement through a salary reduction arrangement with the employee.

Automatic enrollment for employee sponsored health benefits

An employer that elects to offer health benefit plans must provide each employee with a 30–day opt-out period after the employee becomes eligible for employer-provided coverage in which to either decline coverage entirely of affirmatively enroll in a health plan. At the end of the 30–day period, if the employee does not make an affirmative election with respect to health coverage, the employer must automatically enroll the employee for individual (not family) coverage in the employer-sponsored health benefit plan with the lowest applicable employee premium.

Employers are required, within a reasonable period before the beginning of each plan year, to provide employees with written notice of employees' rights and obligations relating to automatic enrollment. The notice must be both comprehensive in scope (for example, it must explain opt-out and affirmative election rights) and easily understood by the average employee to whom it pertains. Specifically, the notice must explain an employee's right to make an affirmative election as to health coverage rather than being automatically enrolled; and, if more than one level of benefits or employee premium is offered by the employer, the notice must explain in which level of benefits and employee premium the employee will be automatically enrolled absent an affirmative election.

Provision of information to multiple agencies

Employers that offer health benefit plans are required to provide the Health Choices Commissioner, and the Secretaries of Labor, Health and Human Services, and the Treasury with information required by the Health Choices Commissioner to ascertain compliance with the provision's requirements.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

D. Employer Contributions in Lieu of Coverage (sec. 313 of the bill)

PRESENT LAW

For employers who choose to provide coverage for their employees, the cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[18] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[19]

[18] Sec. 162. However, see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

[19] Secs. 3121(a)(2) and 3306(b)(2).

REASONS FOR CHANGE

If an employer offers coverage and some employees make an affirmative choice not to enroll in employer-provided plans because they cannot afford the provided coverage, the employers' responsibility to play a role in the provision of health care is not waived if that employee chooses coverage in the Exchange. Employers' contribution in lieu of coverage ensures that employers contribute to the provision of health care for all employees who either accept their employer-sponsored insurance or who seek more affordable coverage in the Exchange. For small businesses, reduced contributions help to ensure that small businesses continue to thrive.

EXPLANATION OF PROVISION

Beginning in the second year after enactment of the provision, employers are required to make contributions to the Health Insurance Exchange for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. The contribution amount is equal to eight percent of the average wages paid by the employer to its employee during the time the employee was enrolled in the non-employer-provided plan. However, contributions are not required if the employee declines coverage because the employee is enrolled in family coverage as a spouse or dependent of another insured. Employers with annual payrolls not exceeding $250,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $250,000 and $400,000 during the preceding calendar year are subject to a reduced rate. Employer contributions are paid to the Health Choices Commissioner and deposited into the Health Insurance Exchange Trust Fund. The contributions are not tied to a particular employee (i.e., the contribution does not subsidize an employee's premium liability). This contribution requirement parallels the payroll tax equal to eight percent of wages that applies to nonelecting employers.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

E. Authority Related to Improper Steering (sec. 314 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The availability of affordability credits for qualifying individuals might lead employers to manipulate their offer of health coverage in order to encourage selection of healthier employees into their health plan while less healthy employees disproportionately join the Exchange. Consequently, the Health Choices Commissioner must be given tools to allow it to address abusive practices and ensure that both employer and Exchange health plans attract a broad range of risk which will promote efficient insurance markets and mitigate adverse selection.

EXPLANATION OF PROVISION

The Health Choices Commissioner (in coordination with the Secretaries of Labor, Health and Human Services, and the Treasury) has the authority to set standards for determining whether employers, in the course of offering coverage, are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing employees to enroll in Exchange-participating health plans rather than in employer-provided plans. An employer found to be violating these standards is treated as not meeting the provision's coverage requirements.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

F. Satisfaction of Health Coverage Participation Requirements Under the Employee Retirement Income Security Act of 1974 (sec. 321 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility in ensuring that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to either offer coverage to their employees or contribute to the cost of health care coverage, and that the most effective means of implementing health care reform is to build on the current system of employer-sponsored health coverage that provides coverage to many American families.

EXPLANATION OF PROVISION

Elections

Under the provision, employers are required to make an affirmative election regarding whether to offer health benefit plans to employees. Employers electing to offer health benefit plans are required to have their plans meet certain minimum coverage requirements. Employers electing to offer health benefit plans are treated as having established and maintained a group health plan for purposes of ERISA, and the provision's health coverage participation requirements are deemed to be part of the terms and conditions of the employer-provided plan.

The Secretary of Labor is required to conduct periodic audits of a representative sampling of employers and employer-provided group health plans in order to discover noncompliance. The Secretary of Labor must share findings of noncompliance with the Secretary of the Treasury and the Health Choices Commissioner, and must take timely enforcement action as appropriate to achieve compliance.

Aggregation rules

For affiliated groups of employers, the identity of the employer would generally be determined by applying the employer aggregation rules in section 414(b), (c), (m), and (o).[20] The same election would apply to all employers in the aggregated group. Employers would be able to make separate elections for employees in separate lines of business, or for full time employees and part time employees.

Noncompliance with coverage requirements

Termination of election

The Secretary of Labor (in coordination with the Health Choices Commissioner) may terminate an employer's election (and thus subject the employer to the payroll tax imposed on employers that do not offer coverage) if the Secretary determines that the employer was substantially noncompliant with the health coverage participation requirements. The Secretary is permitted to promulgate regulations to carry out the provisions of these coverage requirements, and may issue interim final rules as appropriate.

Civil penalties

Employers who elect to provide coverage but whose health benefit plans fail to meet the provision's minimum health coverage participation requirements are subject to penalties of $100 per day for each employee to whom the failure applies.[21] The Secretary of Labor is required to give advance written notification of failure to employers prior to the assessment of a penalty.

The penalties do not apply to (1) periods during which an employer used reasonable diligence but did not discover any failures, and (2) failures that were corrected within 30 days of discovery (but only if such failures were due to reasonable cause and not willful neglect). Penalties imposed on employers for unintentional failures (i.e., due to reasonable cause and not willful neglect) are to be limited to the lesser of 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for group health plans, or $500,000.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

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[20] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements under section 414(m).

[21] The provision permits the penalties to be assessed through an excise tax or a civil penalty under the Employee Retirement Income Security Act of 1974 or the Public Health Service Act. Penalties for any particular failure may not be duplicated, however.

G. Satisfaction of Health Coverage Participation Requirements Under the Internal Revenue Code of 1986 (sec. 322 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility to ensure that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to contribute to the health care coverage of their employees and that such responsibility exists even on the part of employers who choose not to provide health care to their employees.

EXPLANATION OF PROVISION

The provision cross-references the satisfaction of health coverage participation requirements in section 3111(c) of the Code (as added by section 412 of the bill) and the excise tax provisions relating to failures of electing employers to comply with coverage requirements in section 4980H of the Code (as added by section 411 of the bill).

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

H. Satisfaction of Health Coverage Participation Requirements Under the Public Health Service Act (sec. 323 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility in ensuring that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to contribute to the health care coverage of their employees, and that the most effective means of implementing health care reform is to build on the current system of employer-sponsored health coverage that provides coverage to many American families.

EXPLANATION OF PROVISION

Elections

Under the provision, employers are required to make an affirmative election regarding whether to offer health benefit plans to employees. Employers electing to offer health benefit plans are required to have their plans meet certain minimum coverage requirements. Employers electing to offer health benefit plans are treated as having established and maintained a group health plan for pur-

poses of the Public Health Service Act,[22] and the provision's health coverage participation requirements are deemed to be part of the terms and conditions of the employer-provided plan.

The Secretary of Health and Human Services is required to conduct periodic audits of a representative sampling of employers and employer-provided group health plans in order to discover noncompliance. The Secretary of Health and Human Services must share findings of noncompliance with the Secretary of the Treasury and the Health Choices Commissioner, and must take timely enforcement action as appropriate to achieve compliance.

Aggregation rules

For affiliated groups of employers, the identity of the employer would generally be determined by applying the employer aggregation rules in section 414(b), (c), (m), and (o).[23]

Noncompliance with coverage requirements

Termination of election

The Secretary of Health and Human Services (in coordination with the Health Choices Commissioner) may terminate an employer's election (and thus subject the employer to the payroll tax imposed on employers that do not offer coverage) if the Secretary determines that the employer was substantially noncompliant with the health coverage participation requirements. The Secretary is permitted to promulgate regulations to carry out the provisions of these coverage requirements, and may issue interim final rules as appropriate.

Civil penalties

Employers who elect to provide coverage but whose health benefit plans fail to meet the provision's minimum health coverage participation requirements are subject to penalties of $100 per day for each employee to whom the failure applies.[24] The Secretary of Health and Human Services is required to give advance written notification of failure to employers prior to the assessment of a penalty.

The penalties do not apply to (1) periods during which an employer used reasonable diligence but did not discover any failures, and (2) failures that were corrected within 30 days of discovery (but only if such failures were due to reasonable cause and not willful neglect). Penalties imposed on employers for unintentional failures (i.e., due to reasonable cause and not willful neglect) are to be limited to the lesser of 10 percent of the aggregate amount paid

[22] 42 U.S.C. 6A.

[23] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements under section 414(m). The same election would apply to all employers in the aggregated group. Employers would be able to make separate elections for employees in separate lines of business, or for full time employees and part time employees.

[24] The provision permits the penalties to be assessed through an excise tax or a civil penalty under the Employee Retirement Income Security Act of 1974 or the Public Health Service Act. Penalties for any particular failure may not be duplicated, however.

or incurred by the employer during the preceding taxable year for group health plans, or $500,000.

The Secretary of Health and Human Services is permitted to bring a civil action in any United States District Court to collect civil penalties.

Regulations

The Secretary of Health and Human Services is permitted to promulgate regulations to carry out the terms of the provision, and may issue interim final rules as appropriate.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

I. Additional Rules Relating to Health Coverage Participation Requirements (sec. 324 of the bill)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The reforms implemented by the bill must be interpreted and enforced in a uniform and consistent manner so that American families and businesses can realize the benefits provided by comprehensive health reform. Requiring the Exchange and the Departments of Health and Human Services, Labor, and Treasury to develop coordinated interpretative and enforcement measures with respect to employer-provided health care furthers this objective.

EXPLANATION OF PROVISION

The Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury are required to execute an interagency memorandum of understanding to ensure coordination with respect to regulations, rulings, interpretations, and enforcement of the employer responsibility requirements relating to the offering of health insurance set forth in the Code and the parallel provisions in ERISA and the Public Health Service Act. The interagency memorandum must provide that in the case of multiemployer group health plans[25] the health coverage participation requirements apply to the plan sponsor and the contributing sponsors of the plan.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

[25] A multiemployer plan is a collectively bargained plan maintained by more than one employer, usually within the same or related industries, and a labor union. ERISA sec. 3(37).

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

A. Tax on Individuals Without Acceptable Health Care Coverage (sec. 401 of the bill and new Code sec. 59B)

PRESENT LAW

No provision.

REASONS FOR CHANGE

A tax on individuals who opt not to purchase health insurance creates an incentive for uninsured individuals to purchase insurance. Consequently, the tax will enhance the effects of insurance market reforms that are a critical component of comprehensive healthcare reform. The Committee believes that a fair tax is based on the individual's ability to pay, but should be capped at the average cost of health insurance premiums in the national market.

EXPLANATION OF PROVISION

Maintenance of health insurance coverage

An individual (or a husband and wife in the case of a joint return) who does not maintain acceptable health insurance coverage for themselves and each of their qualifying children[26] is subject to an additional tax. The tax is equal to the lesser of (a) the national average premium for single or family coverage, as applicable, as determined by the Secretary of Treasury in coordination with the Health Choices Commissioner[27] or (b) 2.5 percent of the excess of the taxpayer's adjusted gross income ("AGI") over the threshold amount of income required for income tax return filing for that taxpayer under section 6012(a)(1).[28] For purposes of calculating the tax, a taxpayer's modified AGI is calculated by adding any tax-exempt interest or foreign earned income to the individual's AGI. Any individual who is a bona fide resident of a possession of the United States (as determined under section 937(a)) (and any qualifying child residing with the individual) is treated as maintaining accept-

[26] Under section 152(c), a child generally is a qualifying child of a taxpayer if the child satisfies each of five tests: (1) the child has the same principal place of abode as the taxpayer for more than one-half the taxable year; (2) the child has a specified relationship to the taxpayer; (3) the child has not yet attained a specified age; (4) the child has not provided over one-half of their own support for the calendar year in which the taxable year of the taxpayer begins; and (5) the qualifying child has not filed a joint return (other than for a claim of refund) with their spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins. A tie-breaking rule applies if more than one taxpayer claims a child as a qualifying child. The specified relationship is that the child is the taxpayer's son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, or a descendant of any such individual. With respect to the specified age, a child must be under age 19 (or under age 24 in the case of a full-time student). However, no age limit applies with respect to individuals who are totally and permanently disabled within the meaning of section 22(e)(3) at any time during the calendar year. Other rules may apply. The provision includes a special rule under which a child is treated as a qualifying child of an individual for purposes of the provision (and not the qualifying child of any other individual) if such individual is required to provide health care coverage for the child pursuant to a child support order.

[27] Under the other provisions of the bill, a new independent agency is established called the Health Choices Administration which is headed by a Health Choices Commissioner. The Health Choices Commissioner will establish qualified plan standards, establish and operate the Health Insurance Exchange, administer the Individual Affordability Credits and perform other functions.

[28] Generally, in 2009, the filing threshold is $9,350 for a single person or a married person filing separately and is $18,700 for married filing jointly. 1R–2008–117, Oct 16, 2008.

able coverage. This tax is in addition to both the regular income tax and the alternative minimum tax.

Under the provision, acceptable coverage includes coverage under a qualified health plan, a grandfathered plan, Medicare, Medicaid, Tricare (and other Armed Services coverage), Veterans Administration coverage[29] and other coverage approved by the Secretary of the Treasury in coordination with the Health Choices Commissioner.

A qualified health plan generally is a health plan that covers at least an essential benefits package and that includes certain specified limits on required cost sharing, no annual or lifetime limit on covered health care items or services, certain specified minimum services, and certain requirements as to network adequacy as determined by the Health Choices Commissioner.[30] A grandfathered plan generally is a health insurance plan purchased in the individual market in which the taxpayer was enrolled prior to date of enactment and the terms or conditions of which are not changed subsequent to the date of enactment other than to reflect area changes.[31] Certain group coverage in effect on the general effective date of the insurance market reforms of the bill (i.e., after December 31, 2012) also qualifies as grandfathered coverage, but only for the five year period following the general effective date.

Exceptions

The additional tax applies to United States citizens and resident aliens.[32] The additional tax does not apply for non-resident aliens or U.S. citizens and residents who satisfy the definition of a qualified individual, as defined by section 911(d) (relating to individuals whose tax home is in a foreign country and who reside in a foreign country for certain minimum specified time periods). The additional tax does not apply if the maintenance of acceptable coverage would result in a hardship to the individual. The additional tax does not apply if the person's income is below the threshold for filing a Federal income tax return.[33] The additional tax also does not apply to any individual (or any qualifying child of the individual) if the individual has in effect an exemption which certifies that the individual is a member of a religious sect described in section 1402(g)(1) and an adherent of established tenets of such sect or division described in section 1402(g)(1).[34] For taxpayers who main-

[29] Veterans' Administration coverage is acceptable coverage only if the coverage is not less than a level specified by the Secretary of the Treasury and the Secretary of Veterans Affairs, in coordination with the Health Choices Commissioner, based on the individual's priority for services.

[30] These requirements are detailed in the other provisions of the bill.

[31] The definition of grandfathered plan is set forth in the other provisions of the bill. No new enrollment is permitted in grandfathered plans (other than dependents of individuals already enrolled).

[32] Under section 7701(b)(1)(A), an alien is considered a resident of the United States if the individual: (1) is a lawful permanent U.S. resident (the "green card test") at any time during the relevant year; (2) is present in the United States for 31 or more days during the current calendar year and has been present in the United States for a substantial period of time—during a three-year period, 183 or more days weighted toward the present year (the "substantial presence test"); or (3) makes a "first-year election" to be treated as a resident of the United States (a numerical formula under which an alien may pass the substantial presence test one year earlier than under normal rules).

[33] Generally, in 2009, the filing threshold is $9,350 for a single person or a married person filing separately and is $18,700 for married filing jointly. IR–2008–117, Oct. 16, 2008.

[34] Sections 1402(g) and 3127 (incorporating section 1402(g) by reference) provide a process for individuals (and employers for themselves and their employees) to file for an exemption from

Continued

tain insurance for only part of the year, their annual tax is calculated and then pro-rated for the duration of time when insurance was not maintained. Lastly, the additional tax does not apply to an individual if the individual is (or may be) claimed as a dependent on the income tax return of another taxpayer for the taxable year. However, parents or guardians claiming qualified children as dependents on their Federal income tax returns are required to maintain coverage for these dependents.

Delegation of regulatory authority

The provision delegates authority to the Secretary of the Treasury to issue regulations or other guidance as necessary to carry out the purposes of the provision. The provision specifically directs the Secretary to issue guidance to provide an exemption from the tax for de minimis lapses of acceptable coverage and a process for applying for a waiver of the requirement to maintain coverage in cases of hardship (due to cost, or otherwise). The exemption for de minimis lapses of acceptable coverage includes lapses of a short duration that arise on account of a change in an individual's employer or employment status. For example, the additional tax is not intended to apply to a reservist who is deactivated from active duty and obtains coverage within a reasonable time period after the expiration of military coverage. In developing guidance in these two specific areas, the Secretary of the Treasury is directed to coordinate with the Health Choices Commissioner.

Information reporting

The new additional tax for failure to maintain health insurance is accompanied by new reporting requirements for providers of insurance coverage. The provider of acceptable coverage is required to supply information to the Department of the Treasury and the primary insured individual including the name, address and taxpayer identification numbers of all individuals receiving insurance under the policy by January 31 of the year following the calendar year for which the insurance was provided. Failure to file the required information return or to include complete and correct information on the required return is subject to the failure to file correct information returns penalty of section 6721.

EFFECTIVE DATE

The new additional tax is effective for taxable years beginning after December 31, 2012. The information reporting is effective for calendar years beginning after December 31, 2012.

B. Election to Satisfy Health Coverage Participation Requirements (sec. 411 of the bill and new sec. 4980H of the Code)

PRESENT LAW

The Code does not require employers to provide health insurance to employees, and it does not provide a tax credit for any employer

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the self-employment tax and Federal Insurance Contributions Act ("FICA") tax if, among other requirements, they are members of a recognized religious sect that has established tenets or teachings by which individuals are conscientiously opposed to the acceptance of any private or public insurance which makes payments in the event of death, disability, old age, retirement or makes payments toward the cost of, or provides services for, medical care.

that does provide health coverage for its employees. The cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[35] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[36]

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-provided health coverage under an accident or health plan.[37] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from the gross income of the employee.[38] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pretax basis through salary reduction.[39] Such salary reduction contributions are treated as employer contributions and thus are also excluded from gross income.

The Employee Retirement Income Security Act of 1974 ("ERISA")[40] preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance with certain rules if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")[41] and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[42] adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to $100 per day per failure during the period of noncompli-

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[35] Sec. 162. However, see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.
[36] Secs. 3121(a)(2) and 3306(b)(2).
[37] Sec. 106.
[38] Sec. 105(b).
[39] Sec. 125.
[40] Pub. L. No. 43–406.
[41] Pub. L. No. 99–272.
[42] Pub. L. No. 104–191.

ance and generally is imposed on the employer sponsoring the plan.[43]

Under Medicaid, states may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his or her employer, the coverage must be comprehensive and cost-effective for the State. A 2007 analysis showed that 12 states had Medicaid premium assistance programs as authorized under current law.[44]

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility in ensuring that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to contribute to the health care coverage of their employees, and that the most effective means of implementing health care reform is to build on the current system of employer-sponsored health coverage that provides coverage to many American families.

EXPLANATION OF PROVISION

Elections

Under the provision, employers are required to make an affirmative election regarding whether to offer health benefit plans to employees. Employers electing to offer health benefit plans must meet certain minimum benefit and contribution requirements. Employers choosing not to offer health benefit plans, or offering plans that do not meet the minimum benefit and contribution requirements, are subject to a payroll tax (as described in section 412 of the bill).[45]

The Secretary of the Treasury will prescribe rules for employer elections regarding coverage, including rules for the time, manner and form of elections, and the treatment of affiliated groups of employers, separate lines of business, and full versus part time employees.[46] Employers are required to provide verification of their compliance with the provision's health coverage participation requirement to the Health Choices Commissioner and to the Secretaries of Labor, Health and Human Services, and the Treasury.

Parallel provisions for this election (including termination of the election) are provided in ERISA and the Public Health Service Act ("PHSA").[47] The Secretary of the Treasury shares authority for providing rules for employers making this election, and authority to

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[43] Secs. 4980B and 4980D.

[44] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, "The State Children's Health Insurance Program," Powerpoint Presentation, March 5, 2007, p. 14.

[45] There is an exception for certain small employers. Employers with annual payrolls not exceeding $250,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $250,000 and $400,000 during the preceding calendar year are subject to a reduced rate.

[46] Employers electing to offer health benefit plans are to be treated as having established and maintained a group health plan for purposes of ERISA and the Public Health Service Act ("PHSA") (42 U.S.C. 6A) and the provision's health coverage participation requirements are deemed to be part of the terms and conditions of the employer-provided plan.

[47] 42 U.S.C. 6A.

terminate the election, with the Secretaries of Labor and Health and Human Services.

Aggregation rules

For affiliated groups of employers, the identity of the employer is generally determined by applying the employer aggregation rules in section 414(b), (c), (m), and (0).[48] The same election must apply to all employers in the aggregated group. Employers are able to make separate elections for employees in separate lines of business, or for full time employees and part time employees.

Contribution requirements

Employers that elect to offer health benefit plans are required to offer individual and family coverage under a qualified health benefit plan (or certain grandfathered health insurance plans)[49] and to make contributions to help discharge the coverage costs of employees.[50] For full time employees, the contribution amount is required to be at least 72.5 percent of the lowest cost plan offered by the employer which meets the requirements of the essential benefits package[51] (65 percent for eligible employees electing family coverage). For part time employees, the contribution amount is a fraction (as determined in accordance with rules of the Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury, as applicable) of the minimum contributions made for full time employees, with such fraction being equal to a ratio of the average weekly hours worked by the employee compared to the minimum weekly hours specified by the Health Choices Commissioner. An employer cannot satisfy the minimum contribution requirement through a salary reduction arrangement with the employee.

Noncompliance with coverage requirements

Employers who elect to provide coverage but whose health benefit plans fail to meet the provision's minimum health coverage participation requirement are subject to an excise tax of $100 per

[48] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements under section 414(m).

[49] For a plan to be a "qualified health benefits plan" it needs to meet certain minimum coverage requirements, but it need not be offered through the Health Insurance Exchange.

[50] Beginning in the second year after the general effective date of the insurance market reforms of the bill, employers are required to make contributions to the Health Insurance Exchange for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. The contribution amount is equal to eight percent of the average wages paid by the employer to its employee during the time the employee was enrolled in the non-employer-provided plan. Employers with annual payrolls not exceeding $250,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $250,000 and $400,000 during the preceding calendar year are subject to a reduced rate. Employer contributions are paid to the Health Choices Commissioner and deposited into the Health Insurance Exchange Trust Fund. The contributions are not tied to a particular employee (i.e., the contribution does not subsidize an employee's premium liability). This contribution requirement parallels the payroll tax equal to eight percent of wages that applies to nonelecting employers.

[51] The essential benefits package includes certain specified limits on required cost sharing, bans annual or life time limits on covered health care items or services and certain specified minimum services, and imposes certain requirements as to network adequacy as determined by the Health Choices Commissioner.

day for each employee to whom the failure applies.[52] The excise tax does not apply to (1) periods during which an employer used reasonable diligence but did not discover any failures, and (2) failures that are corrected within 30 days of discovery (but only if such failures are due to reasonable cause and not willful neglect). Excise taxes imposed on employers for unintentional failures (i.e., due to reasonable cause and not willful neglect) are limited to the lesser of 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for group health plans, or $500,000. There are parallel civil penalties provided in ERISA and PHSA.[53] The excise tax with respect to any failure is reduced (but not below zero) by the amount of any civil penalty collected under these parallel provisions. The Secretary is also able to terminate an employer's election (and thus subject the employer to the payroll tax imposed on employers that do not offer coverage) if it is determined that the employer was substantially noncompliant with health coverage participation requirements.

Multi-agency coordination

The Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury are required to execute an interagency memorandum of understanding to ensure coordination with respect to regulations, rulings, interpretations, and enforcement of the provision and the parallel provisions in ERISA and PHSA. The Secretaries of Labor and Health and Human Services are required to conduct periodic audits of employers in order to discover any noncompliance with health coverage participation requirements. The Secretaries of Labor, Health and Human. Services, and the Treasury, and the Health Choices Commissioner are all informed of audit results.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

C. Responsibilities of Nonelecting Employers (sec. 412 of the bill and sec. 3111(c) of the Code)

PRESENT LAW

In general

An employer's payroll tax obligations are not affected by its determination whether to offer health insurance coverage to its employees.

Under the Federal Insurance Contributions Act ("FICA"), separate taxes are imposed on every employer and employee with re-

[52] Under the provision, there is created within the Treasury of the United States a trust fund known as the "Health Insurance Exchange Trust Fund" which consists of such amount as may be appropriated or credited to the trust fund. Under the provision, an amount equal to these excise taxes received from non compliant employers is automatically appropriated to, and thus used to fund, the new Health Insurance Exchange Trust Fund.

[53] The provision permits the penalties to be assessed through an excise tax or through a civil penalty under ERISA or PHSA. Penalties for any particular failure are not to be duplicated, however. The Secretary of Labor or Health and Human Services, as appropriate, is required to give advance written notification of failure to employers prior to the assessment of a penalty. The Secretary of Health and Human Services is able to bring civil actions in Federal court to collect civil penalties assessed under PHSA.

spect to wages paid by the employer to the employee.[54] These two taxes are commonly referred to as the employer's and the employee's share of FICA. The employee's share of FICA is collected by means of payroll withholding by the employee's employer.

For both the employer and the employee's share of FICA, the tax consists of two parts: (1) old age, survivor, and disability insurance ("OASDI"), which correlates to the Social Security program that provides monthly benefits after retirement, disability, or death;[55] and (2) Medicare hospital insurance ("HI").[56] The OASDI tax rate is 6.2 percent on both the employee and employer (for a total rate of 12.4 percent). The OASDI tax rate applies to wages up to the OASDI wage base ($106,800 for 2009). The HI tax rate is 1.45 percent on both the employee and the employer (for a total rate of 2.9 percent). Unlike the OASDI tax, the HI tax is not limited to a specific amount of wages, but applies to all wages.

For purposes of the employer's and employee's share of FICA, wages generally means all remuneration for employment including the cash value of all remuneration paid in a medium other than cash. However, the general definition of wages is subject to a number of special rules and exceptions.[57]

Employment for FICA purposes generally means any service of whatever nature performed by an employee for the employer (irrespective of the citizenship or residence of either) within the United States. In the case of service outside the United States, employment also includes service performed by a United States citizen or resident as an employee for an American employer. As in the case of the definition of wages, the definition of employment is also subject to a number of exceptions and special rules.[58] An American employer is defined as an employer which is: (1) the United States or any instrumentality thereof; (2) an individual who is a resident of the United States; (3) a partnership, if at least two-thirds of the partners are United States residents; (4) a trust, if all of the trustees are United States residents; or (5) a corporation organized under the laws of the United States or any of the States.[59]

REASONS FOR CHANGE

The Committee believes that individuals, employers, and the government share responsibility to ensure that all Americans have affordable coverage of essential health benefits. The Committee believes that employers have a particular responsibility to contribute to the health care coverage of their employees and that such responsibility exists even on the part of employers who choose not to provide health care to their employees. The Committee recognizes, however, that small businesses face special challenges in providing

[54] Secs. 3101–3128 (FICA). Sections 3501–3510 provide additional rules.

[55] Pursuant to sec. 201(a) and (b) of the Social Security Act, 42 U.S.C. 401(a) and (b), these OASDI payroll taxes fund the Federal Old and Survivor Insurance Trust Fund and the Federal Disability Trust Fund, respectively. For each fiscal year, an amount equal to the OASDI payroll taxes collected is appropriated for these trust funds.

[56] Pursuant to Sec. 1817 of the Social Security Act, 42 U.S.C. 1395i, the HI payroll taxes fund the Federal Hospital Insurance Trust Fund. For each fiscal year, an amount equal to the HI payroll taxes collected is appropriated for this trust fund.

[57] Sec. 3121(a).

[58] Sec. 3121(b). For example, employment for FICA purposes includes certain service with respect to American vessels or aircrafts and also includes service that is designated-as employment under an agreement entered into under section 233 of the Social Security Act.

[59] Sec. 3121(h).

health coverage to their employees, and thus special rules should be provided for small businesses.

EXPLANATION OF PROVISION

Employers that elect not to provide health benefit plans to their employees are subject to an additional payroll tax equal to eight percent of wages.[60] The provision's definitions of the terms wages, employment, and employer, are generally the same as under present FICA provisions. The provision, however, differs from present law in several respects. First, the tax is imposed as a result of a voluntary election by the employer not to offer an eligible health plan and not to make the required contribution toward each employee's premium for the plan. Second, as is currently the case for HI, there is no taxable wage base for purposes of the new payroll tax. Third, the definition of employment includes services performed by certain foreign agricultural workers, aliens performing services pursuant to certain nonimmigrant visas, and government workers, among others who are carved out under current law.

Employers are permitted to make separate elections for separate lines of business, or full-time employees and part-time employees (or vice-versa). The new payroll tax applies only to wages paid to employees who are not offered health benefits by their employers.

There is an exception and a reduced rate structure for certain small employers. Employers with annual payrolls not exceeding $250,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $250,000 and $400,000 during the preceding calendar year are subject to a reduced rate, as follows: two percent if the annual payroll does not exceed $300,000; four percent if the annual payroll exceeds $300,000 but does not exceed $350,000; and six percent if the annual payroll exceeds 350,000 but does not exceed $400,000. Annual payroll is defined as the aggregate wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b)) during the calendar year.

A parallel payroll tax, including the exception and a reduced rate structure for small employers, applies to railroad carriers.

Territories and possessions of the United States are not treated as States for purposes of the new payroll tax.

EFFECTIVE DATE

The provision is effective for periods beginning after December 31, 2012.

[60] Under the provision, there is created within the Treasury of the United States a trust fund known as the "Health Insurance Exchange Trust Fund" which consists of such amount as may be appropriated or credited to the trust fund. Under the provision, an amount equal to these payroll taxes received from employers electing not to provide health benefits is automatically appropriated to, and thus used to fund, the new Health Insurance Exchange Trust Fund.

D. Credit For Small Business Employee Health Coverage Expenses (sec. 421 of the bill and new sec. 45R of the Code)

PRESENT LAW

Deduction of employer contributions for health coverage for employees

The Code does not provide a tax credit to any employer for the provision of health coverage for its employees. The cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[61] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[62]

Employer contributions for health coverage

The Code generally provides that employees are not taxed on (that is, may "exclude" from gross income) the value of employer-provided health coverage under an accident or health plan.[63] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from gross income of the employee.[64] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pretax basis through salary reduction.[65] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

REASONS FOR CHANGE

The Committee supports additional incentives and assistance to encourage small business employers with low-wage employees to provide health insurance coverage to their employees. Providing health insurance coverage is particularly challenging for these small business employers. In particular, the cost of health insurance may be disproportionately large as a portion of payroll expenses. The tax credit for qualified employee health coverage expenses is designed to make the provision of health insurance coverage by small business employers of low-wage employees more affordable.

EXPLANATION OF PROVISION

General rule

The provision generally provides a tax credit to a qualified small employer for up to 50 percent of its qualified health coverage expenses for the taxable year. Qualified employee health coverage expenses are, with respect to any employer for any taxable year, the aggregate amount paid or incurred by the employer for coverage of any qualified employee of the employer (including any family coverage which covers the employee) under qualified health coverage. However, for this purpose, amounts paid by the employer do not in-

[61] Sec. 162. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.
[62] Secs. 3121(a)(2) and 3306(b)(2).
[63] Sec. 106.
[64] Sec. 105(b).
[65] Sec. 125.

clude amounts based on a salary reduction election made by an employee under a cafeteria plan (although such amounts are generally treated as an employer contribution). The credit is a general business credit, eligible to be carried back for one year and carried forward for 20 years.

Qualified small employer

A qualified small employer for purposes of the provision is an employer with less than 25 qualified employees employed during the employer's taxable year, and whose average annual employee compensation is less than $40,000. However, the full amount of the credit (50 percent of qualified health coverage expenses) is available only to an employer with no more than 10 qualified employees and whose average annual employee compensation does not exceed $20,000. Average annual employee compensation is determined by dividing the total aggregate compensation for the taxable year of all qualified employees by the number of qualified employees.

Under the provision, an employee is a qualified employee of an employer for a taxable year if the employee receives at least $5,000 of compensation from the employer during the taxable year for services as an employee of a trade or business. Self-employed individuals, including partners and sole proprietors, are treated as employees with respect to a business or partnership that generates net earnings from self employment for the individual but only if the business or partnership also has common law employees who are qualified employees.

For a common law employee, compensation means wages for purposes of income tax withholding plus elective deferrals within the meaning of section 402(g) and compensation deferred under an eligible deferred compensation plan under section 457. For a self-employed individual, compensation means net earnings from self employment, prior to subtracting any elective contributions. These definitions of compensation[66] are used to determine both whether an individual is a qualified employee and to determine average annual employee compensation.

Qualified health coverage and expenses

Qualified health coverage includes two elements. First, the coverage must be acceptable coverage as defined for purposes of the individual responsibility requirement for obtaining health coverage. Second, the coverage must be provided by the employer pursuant to its election to satisfy the employer responsibility requirement by offering coverage, and the employer's contribution toward the cost of the coverage must be at least the minimum required for that purpose.[67] The credit is only available for qualified health expenses paid or incurred by the employer for the purchase of health care coverage.

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[66] The provision specifies that compensation has the same meaning as the definition of compensation for simple plans under section 408(p)(6)(A).

[67] Under the provision, for employers that elect to provide coverage rather than pay an additional payroll tax, employers are required to make contributions to help discharge the coverage costs of employees enrolled in the employer-provided plan. For example, for full-time employees, the contribution amount is required to be at least 72.5 percent of the lowest cost plan meeting the requirements of the essential benefits package (reduced to 65 percent for eligible employees electing family coverage).

Phase out of the credit

If an employer's average annual employee compensation exceeds $20,000, the credit percentage phases out from the maximum available credit of 50 percent. The percentage is reduced by one percentage point for each $400 by which average annual employee compensation exceeds $20,000. For example, a firm with average compensation of $24,000 and 10 or fewer employees is entitled to a 40-percent credit. In general, if such firm had qualified employee health coverage expenses of $50,000, the credit amount would equal 40 percent of $50,000, or $20,000.

The credit amount determined above is subject to a further phaseout for employers with more than 10 qualified employees. For employers with more than 10 qualified employees, the credit amount is reduced by an amount which bears the same ratio to the amount of the credit as the number of qualified employees of the employer in excess of 10 bears to 15. For example, if a firm has 16 qualified employees, the credit amount is reduced by 40 percent.[68] In the example above, the $20,000 credit is thus reduced by $8,000 (40 percent of $20,000) to a credit of $12,000.

Special rules

The employer is determined by applying the employer aggregations rules in section 414(b), (c), (m), and (o) and treating the aggregated group of employers as a single employer.[69] Thus, all employees of the aggregated group are taken into account in determining if the employer is a qualified small employer. The credit is not available with respect to qualified employee health coverage expenses for any employee if the employee's compensation for the taxable year exceeds $80,000. Under the provision, the employer generally is allowed a deduction under section 162 for qualified employee health coverage expenses equal to total health coverage expenses minus the dollar amount of the credit. The $5,000 compensation threshold for identifying qualified employees, the $20,000 average annual compensation limit, and the $80,000 compensation amount are indexed to changes in the consumer price index for all urban consumers ("CPI–U"). However, in each case, if the resulting amount is not a multiple of $50, the amount is rounded down to the next lowest multiple of $50.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2012.

[68] (16–10)/115 = 40 percent.

[69] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements of section 414(m).

E. Disclosures to Carry Out Health Insurance Exchange Subsidies (sec. 431 of the bill and sec. 6103(1)(21) of the Code)

PRESENT LAW

Section 6103 provides that returns and return information are confidential and may not be disclosed by the Internal Revenue Service ("IRS"), other Federal employees, State employees, and certain others having access to such information except as provided in the Internal Revenue Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B Premium Subsidy Adjustment.[70]

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information.[71] Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution.[72] The unauthorized inspection of a return or return information is punishable by a fine not exceeding $1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution.[73] An action for civil damages also may be brought for unauthorized disclosure.[74]

REASONS FOR CHANGE

The bill creates within the Health Choices Administration a National Health Insurance Exchange ("Exchange") to facilitate the purchase of health insurance. A State has the option of forming its own health insurance exchange at the State level that must be approved for operation by the Federal government ("approved State Exchange"). The bill provides for "affordability credits," administered by the Exchanges, which subsidize the purchase of health insurance through the Exchanges and the cost of paying for medical care. The affordability credits generally are available on a sliding scale for persons and families with incomes between Medicaid eligibility and 400 percent of the poverty level. To ensure the appropriate level of subsidy is delivered to American families, the Committee believes it is appropriate to allow for the disclosure of certain tax return information to the Exchange, or approved State Exchange to administer the affordability credits.

EXPLANATION OF PROVISION

Upon receipt of a valid written request from the Health Choices Commissioner or the head of the approved State Exchange, the IRS is authorized to disclose limited return information of any taxpayer whose income is relevant in determining the amount of the afford-

[70] Sec. 6103(1)(20).
[71] Sec. 6103(p)(4)(D).
[72] Sec. 7213.
[73] Sec. 7213A.
[74] Sec. 7431.

ability credit(s). Such return information is limited to (1) taxpayer identity information, (2) filing status, (3) modified adjusted gross income, (4) the number of dependents of the taxpayer, (5) such other information as is prescribed by the Secretary by regulation as might indicate that the taxpayer is eligible for such affordability credit(s) (and the amount thereof), and (6) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

The return information disclosed is to be used by officers and employees of the Health Choices Administration, or approved State Exchange, only for the purposes of and to the extent necessary in establishing and verifying the appropriate amount of any affordability credit and providing for the repayment of any such credit that was in excess of the appropriate amount.

The general rule of confidentiality applies to the information disclosed, as well as the safeguard requirements, penalties, and civil damage remedies for unauthorized disclosure or inspection.

EFFECTIVE DATE

The provision is effective on the date of enactment.

F. Surcharge on High-Income Individuals (sec. 441 of the bill and new sec. 59C of the Code)

PRESENT LAW

In general

An individual who is a citizen or resident of the United States is subject to income tax on his or her taxable income.[75] An individual computes taxable income by reducing gross income by the sum of (i) the deductions allowable in computing adjusted gross income, (ii) the standard deduction (or itemized deductions, at the election of the taxpayer), and (iii) the deduction for personal exemptions. Graduated tax rates are then applied to a taxpayer's taxable income to determine his or her individual income tax liability. Lower rates apply to net capital gain and qualified dividend income. A taxpayer may also be subject to an alternative minimum tax. A taxpayer may reduce his or her income tax liability by certain tax credits.

Gross income

Gross income means income from whatever source derived other than certain items excluded from gross income. Sources of gross income generally include, among other things, compensation for services, interest, dividends, capital gains, rents, royalties, alimony and separate maintenance payments, annuities, income from life insurance and endowment contracts (other than certain death benefits), pensions, gross profits from a trade or business, income in respect

[75] Foreign tax credits generally are available against U.S. income tax imposed on foreign source income to the extent of foreign income taxes paid on that income. A nonresident alien generally is subject to the U.S. individual income tax only on income with a sufficient nexus to the United States.

of a decedent, and income from S corporations, partnerships,[76] trusts or estates.[77] Exclusions from gross income include death benefits payable under a life insurance contract, interest on certain State and local bonds, employer-provided health insurance, employer-provided pension contributions, and certain other employer-provided benefits.

Adjusted gross income

An individual's adjusted gross income ("AGI") is determined by subtracting certain allowable deductions from gross income. These deductions are known as "above-the line" deductions. These deductions are generally the deductions incurred to produce gross income. For example, these deductions include trade or business deductions (such as cost of goods sold, small business expensing, depreciation, the domestic production activities deduction, and compensation paid to employees), losses from the sale or exchange of property, deductions attributable to rents and royalties, contributions to pensions and other retirement plans, and moving expenses. Thus, AGI generally is an approximation of "economic income."

Some deductions are not allowable in computing adjusted gross income. These deductions generally are referred to as itemized deductions. The principal itemized deductions are the deductions for interest on a personal residence and investment interest, taxes, charitable contributions, nonbusiness casualty and theft losses, investment expenses, medical and dental expenses, and certain employee expenses. An individual who does not elect to deduct itemized deductions is allowed a standard deduction, which also is not allowable in computing adjusted gross income.

REASONS FOR CHANGE

The Committee strongly believes that health care reform should not add to the Federal deficit. The Committee also believes that a surcharge on the highest income individuals increases fairness and progressivity in the tax Code. It also fulfills the goal of not adding to the tax burden of the large majority of taxpayers. The Committee also believes that the lower levels of the surcharge should not apply if cost savings from health care reform satisfy certain goals.

EXPLANATION OF PROVISION

The bill imposes a tax at the rates of one percent, 1.5 percent, and 5.4 percent on certain income of high-income individuals. In the case of a joint return or return of a surviving spouse, the one percent rate applies to so much of the taxpayer's modified adjusted gross income as exceeds $350,000 but does not exceed $500,000; the 1.5 percent rate applies to so much of the taxpayer's modified adjusted gross income as exceeds $500,000 but does not exceed

[76] In general, partnerships and S corporations are treated as pass-through entities for Federal income tax purposes. Thus, no Federal income tax is imposed at the entity level. Rather, income of these entities is passed through and taxed to the owners at the individual level.

[77] In general, estates and most trusts pay tax on income at the entity level, unless the income is distributed or required to be distributed under governing law or under the terms of the governing instrument. These entities determine their tax liability using a special tax rate schedule and may be subject to the alternative minimum tax. Other trusts are treated as being owned by grantors in whole or in part for tax purposes; in such cases, the grantors are taxed on the income of the trust.

$1,000,000; and the 5.4 percent rate applies to so much of the modified adjusted gross income as exceeds $1,000,000. In the case of a married individual filing a separate return, the dollar amounts are 50 percent of the above dollar amounts. In the case of unmarried individuals, heads of households and trusts and estates, the dollar amounts are 80 percent of the above dollar amounts. The dollar amounts are indexed for inflation for taxable years beginning after December 31, 2011.

The bill directs the Director of the Office of Management and Budget ("OMB") to determine before December 1, 2012 whether the Federal health reform savings under division B of this bill for the period beginning October 1, 2009 and ending before October 1, 2019, exceed the $525 billion of savings currently estimated by the Congressional Budget Office ("CBO"). If these savings (over $525 billion) do not exceed $150 billion, then the one percent and 1.5 percent rates will become two percent and three percent, respectively, for taxable years beginning after December 31, 2012. If the Director of OMB determines these savings exceed CBO's current estimated savings by more than $150 billion for the period, then the one percent and 1.5 percent rates shall not increase after December 31, 2012. If Director of OMB determines these savings exceed the CBO's current estimated savings by more than $175 billion for the period, then neither the one percent nor 1.5 percent rates shall apply after December 31, 2012. The Committee anticipates that OMB will provide an explanation of its estimate (including a discussion of its key assumptions and estimating techniques) as part of its final determination.

Modified adjusted gross income is the taxpayer's adjusted gross income reduced by the itemized deduction for investment interest.

In the case of a nonresident alien, only amounts taken into account in computing taxable income are taken into account in computing this tax.

In the case of a taxpayer with an amount excluded under section 911 (relating to income earned outside the United States), the dollar amounts applicable to the taxpayer are reduced by the amount of the exclusion (net of disallowed deductions and exclusions).

Charitable trusts are not subject to the tax.

No credits are allowed against this tax and this tax is not taken into account in computing alternative minimum tax liability.

EFFECTIVE DATE

The provision applies to taxable years beginning after December 31, 2010.

G. Distributions for Medicine Qualified Only If for Prescribed Drug or Insulin (sec. 442 of the bill and secs. 105, 106, 220, and 223 of the Code)

PRESENT LAW

Individual deduction for medical expenses

Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 per-

cent of AGI.[78] Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.[79] However, any amount paid during a taxable year for medicine or drugs is explicitly deductible as a medical expense only if the medicine or drug is a prescribed drug or is insulin.[80] Thus, any amount paid for over-the-counter medicine is not deductible as a medical expense.

Exclusion for employer-provided health care

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-provided health coverage under an accident or health plan.[81] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[82] An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending arrangement ("FSA") which allows reimbursement not in excess of a specified dollar amount. Such dollar amount is either elected by an employee under a cafeteria plan ("Health FSA") or otherwise specified by the employer under an arrangement called a health reimbursement arrangement ("HRA"). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The general definition of medical care without the explicit limitation on medicine applies for purposes of the exclusion for employer-provided health coverage and medical care.[83] Thus, under an HRA or under a Health FSA, amounts paid for over-the-counter medicine are treated as medical expenses, and reimbursements for such amounts are excludible from gross income.

Medical savings arrangements

Present law provides that individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may establish and make tax-deductible contributions to a health savings account ("HSA").[84] Subject to certain limitations,[85] contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contribu-

[78] Sec. 213(a).
[79] Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.
[80] Sec. 213(b).
[81] Sec 106.
[82] Sec. 105(b).
[83] Sec. 105(b) provides that reimbursements for medical care within the meaning of section 213(d) pursuant to employer-provided health coverage are excludible from gross income. The definition of medical care in section 213(d) does not include the prescription drug limitation in section 213(b).
[84] Sec. 223.
[85] For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage ($3,050 and $6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

tions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income.[86] The general definition of medical care without the explicit limitation on medicine also applies for purposes of this exclusion.[87] Similar rules apply for another type of medical savings arrangement called an Archer MSA.[88] Thus, a distribution from a HSA or an Archer MSA used to purchase over-the-counter medicine also is excludible as an amount used for qualified medical expenses.

REASONS FOR CHANGE

In 1982, Congress eliminated the individual medical expense deduction for over-the counter medicine (other than insulin) to simplify the deduction, to conform the coverage of the deduction more closely to the coverage of private health insurance policies, and because expenses for over-the-counter medicine are more likely to represent expenses for ordinary consumption than "extraordinary" medical expenses that should be deductible.[89] However, Congress did not similarly remove the cost of over-the-counter medicine from the eligibility for excludible reimbursements under Health FSAs (and in later years, HRAs, HSAs, and Archer MSAs) even though similar reasons for not treating reimbursement for these expenses as excludible from gross income apply. The Committee believes that the treatment of reimbursements for over-the-counter medicine under HRAs, Health FSAs, HSAs, and Archer MSAs should be conformed to the treatment of over-the-counter medicine under the itemized deduction for medical expenses.

EXPLANATION OF PROVISION

Under the provision, with respect to medicines, the definition of medical expense for purposes of employer-provided health coverage (including HRAs and Health FSAs), HSAs, and Archer MSAs, is conformed to the definition for purposes of the itemized deduction for medical expenses. Thus, under the provision, the cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, HRA, HSA, or Archer MSA.

EFFECTIVE DATE

The provision is effective for expenses incurred after December 31, 2009.

H. Delay in Application of Worldwide Allocation of Interest (sec. 443 of the bill and sec. 864 of the Code)

PRESENT LAW

In general

To compute the foreign tax credit limitation, a taxpayer must determine the amount of its taxable income from foreign sources.

[86] Sec. 223(f).
[87] Sec. 223(d)(2).
[88] Sec. 220.
[89] Sec. 213(b) was added by sec. 202 of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248. The reasons for the change to limit the deduction to prescription medicine are described in JCS–38–82 at 24–25.

Thus, the taxpayer must allocate and apportion deductions between items of U.S.-source gross income, on the one hand, and items of foreign-source gross income, on the other.

In the case of interest expense, the rules generally are based on the approach that money is fungible and that interest expense is properly attributable to all business activities and property of a taxpayer, regardless of any specific purpose for incurring an obligation on which interest is paid.[90] For interest allocation purposes, all members of an affiliated group of corporations generally are treated as a single corporation (the so-called "one-taxpayer rule") and allocation must be made on the basis of assets rather than gross income. The term "affiliated group" in this context generally is defined by reference to the rules for determining whether corporations are eligible to file consolidated returns.

For consolidation purposes, the term "affiliated group" means one or more chains of includible corporations connected through stock ownership with a common parent corporation that is an includible corporation, but only if: (1) the common parent owns directly stock possessing at least 80 percent of the total voting power and at least 80 percent of the total value of at least one other includible corporation; and (2) stock meeting the same voting power and value standards with respect to each includible corporation (excluding the common parent) is directly owned by one or more other includible corporations.

Generally, the term "includible corporation" means any domestic corporation except certain corporations exempt from tax under section 501 (for example, corporations organized and operated exclusively for charitable or educational purposes), certain life insurance companies, corporations electing application of the possession tax credit, regulated investment companies, real estate investment trusts, and domestic international sales corporations. A foreign corporation generally is not an includible corporation.

Subject to exceptions, the consolidated return and interest allocation definitions of affiliation generally are consistent with each other.[91] For example, both definitions generally exclude all foreign corporations from the affiliated group. Thus, while debt generally is considered fungible among the assets of a group of domestic affiliated corporations, the same rules do not apply as between the domestic and foreign members of a group with the same degree of common control as the domestic affiliated group.

Banks, savings institutions, and other financial affiliates

The affiliated group for interest allocation purposes generally excludes what are referred to in the Treasury regulations as financial corporations.[92] A financial corporation includes any corporation, otherwise a member of the affiliated group for consolidation purposes, that is a financial institution (described in section 581 or section 591), the business of which is predominantly with persons other than related persons or their customers, and which is re-

[90] However, exceptions to the fungibility principle are provided in particular cases, some of which are described below.

[91] One such exception is that the affiliated group for interest allocation purposes includes section 936 corporations (certain electing domestic corporations that have income from the active conduct of a trade or business in Puerto Rico or another U.S. possession) that are excluded from the consolidated group.

[92] Treas. Reg. sec. 1.861–11T(d)(4).

quired by State or Federal law to be operated separately from any other entity that is not a financial institution.[93] The category of financial corporations also includes, to the extent provided in regulations, bank holding companies (including financial holding companies), subsidiaries of banks and bank holding companies (including financial holding companies), and savings institutions predominantly engaged in the active conduct of a banking, financing, or similar business.[94]

A financial corporation is not treated as a member of the regular affiliated group for purposes of applying the one-taxpayer rule to other non-financial members of that group. Instead, all such financial corporations that would be so affiliated are treated as a separate single corporation for interest allocation purposes.

Worldwide interest allocation

In general

The American Jobs Creation Act of 2004 ("AJCA")[95] modified the interest expense allocation rules described above (which generally apply for purposes of computing the foreign tax credit limitation) by providing a one-time election (the "worldwide affiliated group election") under which the taxable income of the domestic members of an affiliated group from sources outside the United States generally is determined by allocating and apportioning interest expense of the domestic members of a worldwide affiliated group on a worldwide-group basis (i.e., as if all members of the worldwide group were a single corporation). If a group makes this election, the taxable income of the domestic members of a worldwide affiliated group from sources outside the United States is determined by allocating and apportioning the third-party interest expense of those domestic members to foreign-source income in an amount equal to the excess (if any) of (1) the worldwide affiliated group's worldwide third-party interest expense multiplied by the ratio that the foreign assets of the worldwide affiliated group bears to the total assets of the worldwide affiliated group,[96] over (2) the third-party interest expense incurred by foreign members of the group to the extent such interest would be allocated to foreign sources if the principles of worldwide interest allocation were applied separately to the foreign members of the group.[97]

For purposes of the new elective rules based on worldwide fungibility, the worldwide affiliated group means all corporations in an affiliated group as well as all controlled foreign corporations that, in the aggregate, either directly or indirectly,[98] would be members of such an affiliated group if section 1504(b)(3) did not apply (i.e., in which at least 80 percent of the vote and value of the

[93] Sec. 864(e)(5)(C).
[94] Sec. 864(e)(5)(D).
[95] Pub. L. No. 108-357, sec. 401.
[96] For purposes of determining the assets of the worldwide affiliated group, neither stock in corporations within the group nor indebtedness (including receivables) between members of the group is taken into account.
[97] Although the interest expense of a foreign subsidiary is taken into account for purposes of allocating the interest expense of the domestic members of the electing worldwide affiliated group for foreign tax credit limitation purposes, the interest expense incurred by a foreign subsidiary is not deductible on a U.S. return.
[98] Indirect ownership is determined under the rules of section 958(a)(2) or through applying rules similar to those of section 958(a)(2) to stock owned directly or indirectly by domestic partnerships, trusts, or estates.

stock of such corporations is owned by one or more other corporations included in the affiliated group). Thus, if an affiliated group makes this election, the taxable income from sources outside the United States of domestic group members generally is determined by allocating and apportioning interest expense of the domestic members of the worldwide affiliated group as if all of the interest expense and assets of 80-percent or greater owned domestic corporations (i.e., corporations that are part of the affiliated group, as modified to include insurance companies) and certain controlled foreign corporations were attributable to a single corporation.

Financial institution group election

Taxpayers are allowed to apply the bank group rules to exclude certain financial institutions from the affiliated group for interest allocation purposes under the worldwide fungibility approach. The rules also provide a one-time financial institution group election that expands the bank group. At the election of the common parent of the preelection worldwide affiliated group, the interest expense allocation rules are applied separately to a subgroup of the worldwide affiliated group that consists of (1) all corporations that are part of the bank group, and (2) all financial corporations. For this purpose, a corporation is a financial corporation if at least 80 percent of its gross income is financial services income (as described in section 904(d)(2)(C)(i) and the regulations thereunder) that is derived from transactions with unrelated persons.[99] For these purposes, items of income or gain from a transaction or series of transactions are disregarded if a principal purpose for the transaction or transactions is to qualify any corporation as a financial corporation.

In addition, anti-abuse rules are provided under which certain transfers from one member of a financial institution group to a member of the worldwide affiliated group outside of the financial institution group are treated as reducing the amount of indebtedness of the separate financial institution group. Regulatory authority is provided with respect to the election to provide for the direct allocation of interest expense in circumstances in which such allocation is appropriate to carry out the purposes of these rules, to prevent assets or interest expense from being taken into account more than once, or to address changes in members of any group (through acquisitions or otherwise) treated as affiliated under these rules.

Effective date of worldwide interest allocation

The common parent of the domestic affiliated group must make the worldwide affiliated group election. It must be made for the first taxable year beginning after December 31, 2010, in which a worldwide affiliated group exists that includes at least one foreign corporation that meets the requirements for inclusion in a worldwide affiliated group.[100] The common parent of the pre-election worldwide affiliated group must make the election for the first taxable year beginning after December 31, 2010, in which a worldwide

[99] See Treas. Reg. sec. 1.904–4(e)(2).

[100] As originally enacted under AJCA, the worldwide interest allocation rules were effective for taxable years beginning after December 31, 2008. However, the Housing and Economic Recovery Act of 2008 ("HERA") delayed the implementation of the worldwide interest allocation rules for two years, until taxable years beginning after December 31, 2010. Pub. L. No. 110–289, sec. 3093.

affiliated group includes a financial corporation. Once either election is made, it applies to the common parent and all other members of the worldwide affiliated group or to all members of the financial institution group, as applicable, for the taxable year for which the election is made and all subsequent taxable years, unless revoked with the consent of the Secretary of the Treasury.

Phase-in rule

HERA also provided a special phase-in rule in the case of the first taxable year to which the worldwide interest allocation rules apply. For that year, the amount of the taxpayer's taxable income from foreign sources is reduced by 70 percent of the excess of (i) the amount of its taxable income from foreign sources as calculated using the worldwide interest allocation rules over (ii) the amount of its taxable income from foreign sources as calculated using the present-law interest allocation rules. For that year, the amount of the taxpayer's taxable income from domestic sources is increased by a corresponding amount. Any foreign tax credits disallowed by virtue of this reduction in foreign-source taxable income may be carried back or forward under the normal rules for carrybacks and carryforwards of excess foreign tax credits.

REASONS FOR CHANGE

The Committee believes that it is appropriate to delay implementation of the worldwide interest allocation rules.

EXPLANATION OF PROVISION

The provision delays the effective date of worldwide interest allocation rules for nine years, until taxable years beginning after December 31, 2019. The required dates for making the worldwide affiliated group election and the financial institution group election are changed accordingly.

The provision also eliminates the special phase-in rule that applies in the case of the first taxable year to which the worldwide interest allocation rules apply.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2010.

I. Limitation on Treaty Benefits for Certain Deductible Payments (sec. 451 of the bill and sec. 894 of the Code)

PRESENT LAW

In general

The United States taxes foreign corporations only on income that has a sufficient nexus to the United States. Thus, a foreign corporation is generally subject to net-basis U.S. tax only on income that is effectively connected with the conduct of a trade or business in the United States. Such effectively connected income generally is taxed in the same manner and at the same rates as the income of a U.S. corporation. An applicable tax treaty may limit the imposition of U.S. tax on business operations of a foreign corporation to

cases in which the business is conducted through a permanent establishment in the United States.

In addition, foreign corporations generally are subject to a gross-basis U.S. tax at a flat 30-percent rate on the receipt of interest, dividends, rents, royalties, and certain similar types of income derived from U.S. sources, subject to certain exceptions. The tax ("U.S. withholding tax") generally is collected by means of withholding by the person making the payment. U.S. withholding tax may be reduced or eliminated under an applicable tax treaty, subject to the conditions discussed below.

Tax treaties

A foreign corporation may not benefit from a provision of a U.S. tax treaty with a foreign country that eliminates or reduces U.S. withholding tax unless the foreign corporation is both a resident of such foreign country and qualifies under any limitation-on-benefits provision contained in the U.S. tax treaty with such foreign country. In general, a foreign corporation is a resident of a foreign country under a U.S. tax treaty with that foreign country if it is liable to tax in that country by reason of its domicile, residence, citizenship, place of management, place of incorporation, or other criterion of a similar nature.[101]

Limitation-on-benefits provisions generally

Limitation-on-benefits provisions in income tax treaties are intended to deny treaty benefits in certain cases of treaty shopping or income stripping engaged in by third-country residents. Treaty shopping is said to occur when an entity that is resident in a country with respect to which there is no relevant tax treaty in force (or there is such a treaty in force but the taxpayer desires better benefits than those offered under that treaty) becomes resident in a treaty country or conducts a transaction in such a country for the purpose of qualifying for treaty benefits. For example, treaty shopping by a third-country resident may involve organizing in a treaty country a corporation that is entitled to the benefits of the treaty. Alternatively, a third-country resident eligible for favorable treatment under the tax rules of its country of residency may attempt to reduce the income base of a related treaty-country resident by having that treaty country resident pay to it, directly or indirectly, interest, royalties, or other amounts that are deductible in the treaty country from which the payments are made.

U.S. tax treaties contain a variety of limitation-on-benefits provisions due to the continued and recently accelerated development of limitation-on-benefits concepts, and the negotiated nature of tax treaties in general. Although many older U.S. tax treaties may lack limitation-on-benefits provisions[102] or lack the refinements now thought essential to such provisions, the U.S. model income tax treaty, as most recently revised in 2006 ("U.S. model treaty"),[103] and the newer U.S. treaties include limitation-on-benefits provi-

[101] United States Model Income Tax Convention of November 15, 2006, Art. 4, par. 1.

[102] U.S. income tax treaties with Greece, Hungary, Pakistan, the Philippines, Poland, and Romania are examples of such treaties, each of which entered into force more than 25 years ago. The United States recently concluded negotiations for a new income tax treaty with Hungary that contains a modern limitation-on-benefits provision; the U.S. Senate must still ratify that treaty before it may enter into force.

[103] United States Model Income Tax Convention of November 15, 2006, Art. 22.

sions that limit treaty benefits to resident taxpayers that meet certain detailed requirements intended to minimize these abuses. Present Treasury Department policy, which has been repeatedly ratified by the Senate, is broadly to revise older treaties by tightening limitation-on-benefits provisions to prevent treaty shopping.

The limitation-on-benefits rules included in U.S. income tax treaties and protocols signed since 2001 generally correspond with the limitation-on-benefits provisions of the U.S. model treaty. Certain features of the limitation-on-benefits provisions in recent treaties and protocols, however, differ from the rules in the U.S. model treaty, and some recent treaties and protocols include additional limitation-on-benefits rules not included in the U.S. model treaty. Some of the additions and differences make limitation-on-benefits provisions more restrictive than the rules in the U.S. model treaty, and others make the provisions less restrictive.

The U.S. model treaty limitation-on-benefits provision

The limitation-on-benefits rules of the U.S. model treaty include three provisions under which a resident of a treaty country may qualify for treaty benefits. First, a treaty-country resident may qualify for all treaty benefits if it has any one of several listed attributes. Second, a treaty-country resident that does not have one of the listed attributes may qualify for treaty benefits for income items that are derived from the other treaty country and that are related to a trade or business carried on in the residence country. Third, a treaty-country resident that would not be eligible for treaty benefits under either of the preceding two provisions may qualify for treaty benefits at the discretion of the competent authority of the other treaty country. These three provisions are described in more detail below.

Listed attributes qualifying a treaty-country resident for treaty benefits

A treaty-country resident may qualify for treaty benefits under the U.S. model treaty if it has one of the following attributes: it is (1) an individual; (2) a contracting state or a political subdivision or a local authority of the contracting state; (3) a company that satisfies either a public trading or ownership test described below; (4) a pension fund or other tax-exempt organization (if, in the case of a pension fund, more than 50 percent of the fund's beneficiaries, members, or participants are individuals resident in either treaty country); or (5) a person other than an individual that satisfies the ownership and base erosion test described below.

Public trading and ownership tests.—A company satisfies the public trading test if its principal class of shares (and any disproportionate class of shares) is regularly traded on one or more recognized stock exchanges and either its principal class of shares is primarily traded on one or more recognized stock exchanges located in the treaty country in which the company is a resident or the company's primary place of management and control is in its country of residence. A company may satisfy the ownership test if at least 50 percent of the aggregate vote and value of the company's shares (and at least 50 percent of any disproportionate class of the company's shares) is owned directly or indirectly by five or fewer companies entitled to benefits under the public trading test

described above. This ownership test may be satisfied by indirect ownership only if each intermediate owner is a resident of either treaty country.

Ownership and base erosion test.—A resident of a treaty country satisfies the ownership prong of the ownership and base erosion test if on at least half the days of the taxable year, persons that are residents of that country and that are entitled to treaty benefits as individuals, governments, companies that satisfy the public trading test, or pension funds or other tax-exempt organizations own, directly or indirectly, stock representing at least 50 percent of the aggregate voting power and value (and at least 50 percent of any disproportionate class of shares) of the resident for whom treaty benefit eligibility is being tested. This ownership requirement may be satisfied by indirect ownership only if each intermediate owner is a resident of the country of residence of the person for which entitlement to treaty benefits is being tested. A resident of a treaty country satisfies the base erosion prong of the ownership and base erosion test if less than 50 percent of the person's gross income for the taxable year, as determined in the person's country of residence, is paid or accrued, directly or indirectly, in the form of deductible payments to persons who are not residents of either treaty country entitled to treaty benefits as individuals, governments, companies that satisfy the public trading test, or pension funds or other tax-exempt organizations (other than arm's-length payments in the ordinary course of business for services or tangible property).

Items of income derived from an active trade or business

Under the U.S. model treaty, a resident of a treaty country that is not eligible for all treaty benefits under any of the rules described above may be entitled to treaty benefits with respect to a particular item of income derived from the other treaty country. A resident is entitled to treaty benefits for such an income item if the resident is engaged in the active conduct of a trade or business in its country of residence (other than the business of making or managing investments for the resident's own account, unless these activities are banking, insurance, or securities activities carried on by a bank, an insurance company, or a registered securities dealer) and the income derived from the other treaty country is derived in connection with, or is incidental to, that trade or business. If a resident of a treaty country derives an item of income from a trade or business activity that it conducts in the other treaty country, or derives an income item arising in that other country from a related person, the income item eligibility rule just described is considered satisfied for that income item only if the trade or business activity carried on by the resident in its country of residence is substantial in relation to the trade or business activity carried on by the resident or the related person in the other country. The determination whether a trade or business activity is substantial is based on all the facts and circumstances.

Discretionary grant of benefits by competent authority

A resident of a treaty country not otherwise eligible for treaty benefits under the U.S. model treaty may be eligible for the benefits of the treaty generally or eligible for the benefits with respect

to a specific item of income, based on a determination by the competent authority of the other treaty country. The competent authority may grant such benefits if it determines that the establishment, acquisition, or maintenance of the person for whom treaty benefits eligibility is being tested, and the conduct of that person's operations, did not have as one of its principal purposes the obtaining of benefits under the treaty.

REASONS FOR CHANGE

The Committee is aware that even though many recent U.S. income tax treaties include limitation-on-benefits provisions intended to ensure that only persons with sufficient nexus to the treaty partner countries may obtain treaty benefits, foreign multinational taxpayers residing in countries with which the United States does not have comprehensive tax treaties (including tax havens) may engage in treaty shopping. Treaty shopping by foreign multinational companies may involve organizing, in jurisdictions that have income tax treaties with the United States that offer favorable U.S. withholding rates on deductible payments, subsidiaries with no substantial business activities or other connections to those jurisdictions.[104] Such payments may ultimately be distributed to the foreign parent corporations in the non-tax-treaty jurisdictions, although payments made directly to the parent companies would not have been eligible for reduced treaty withholding rates. The Committee believes that some instances of treaty shopping of the sort described above involve formerly U.S.-based companies that engaged in corporate inversion transactions prior to the enactment of the anti-inversion rules of section 7874. As a result of these inversion transactions, U.S. parent corporations of multinational groups became subsidiaries of foreign corporations organized in low- or no-tax jurisdictions. The Committee believes that it is inappropriate to allow treaty benefits for deductible payments in cases in which a foreign parent corporation would not have qualified for benefits under a U.S. tax treaty if the payment had been made directly to the parent, including in cases in which the parent is resident in a tax haven.

EXPLANATION OF PROVISION

The provision limits tax treaty benefits with respect to U.S. withholding tax imposed on deductible related-party payments. Under the provision, the amount of U.S. withholding tax imposed on deductible related-party payments may not be reduced under any U.S. income tax treaty unless such withholding tax would have been reduced under a U.S. income tax treaty if the payment were made directly to the foreign parent corporation of the payee. A payment is a deductible related-party payment if it is made directly or indirectly by any entity to any other entity, it is allowable as a deduction for U.S. tax purposes, and both entities are members of the same foreign controlled group of entities.

[104] As documented in the Department of the Treasury *Report to the Congress on Earnings Stripping, Transfer Pricing and U.S. Income Tax Treaties,* some of the older U.S. income treaties that do not have limitation-on-benefits provisions, or treaties that lack all of the recent refinements to such provisions, provide for zero or low rates of U.S. withholding on certain deductible payments, including interest. Department of the Treasury, *Report to the Congress on Earnings Stripping, Transfer Pricing and U.S. Income Tax Treaties* 82 (2007).

For purposes of the provision, a foreign controlled group of entities is a controlled group of corporations as defined in section 1563(a)(1), modified as described below, in which the common parent company is a foreign corporation. Such common parent company is referred to as the "foreign parent corporation." A controlled group of corporations consists of a chain or chains of corporations connected through direct stock ownership of at least 80 percent of the total combined voting power of all classes of stock entitled to vote or at least 80 percent of the total value of shares of all classes of stock of each of the corporations. For purposes of the provision, the relevant ownership threshold is lowered from "at least 80 percent" to more than 50 percent, certain members of the controlled group of corporations that would otherwise be treated as excluded members are not treated as excluded members,[105] and insurance companies are not treated as members of a separate controlled group of corporations. In addition, a partnership or other noncorporate entity is treated as a member of a controlled group of corporations if such entity is controlled by members of the group.

The Secretary may prescribe regulations that are necessary or appropriate to carry out the purposes of the provision, including regulations providing for the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and regulations providing for the treatment of any member of a foreign controlled group of entities as the common parent of that group if such treatment is appropriate taking into account the economic relationships among the group entities.

For example, under the provision, a deductible payment made by a U.S. entity to a foreign entity with a foreign parent corporation that is resident in a country with respect to which the United States does not have an income tax treaty is always subject to the statutory U.S. withholding tax rate of 30 percent, irrespective of whether the payee qualifies for benefits under a tax treaty. If, instead, the foreign parent corporation is a resident of a country with respect to which the United States does have an income tax treaty that would reduce the withholding tax rate on a payment made directly to the foreign parent corporation (regardless of the amount of such reduction), and the payment would qualify for benefits under that treaty if the payment were made directly to the foreign parent corporation, then the payee entity will continue to be eligible for the reduced withholding tax rate under the U.S. income tax treaty with the payee entity's residence country (even if such reduced treaty rate is lower than the rate that would be imposed on a hypothetical direct payment to the foreign parent corporation).

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[105] Under section 1563(b)(2), a corporation that is a member of a controlled group of corporations on December 31 of a taxable year is treated as an excluded member of the group for the taxable year that includes such December 31 if such corporation—

(A) is a member of the group for less than one-half the number of days in such taxable year which precedes such December 31;

(B) is exempt from taxation under section 501(a) for such taxable year;

(C) is a foreign corporation subject to tax under section 881 for such taxable year;

(D) is an insurance company subject to taxation under section 801; or

(E) is a franchised corporation (as defined in section 1563(f)(4)).

EFFECTIVE DATE

The provision is effective for payments made after the date of enactment.

J. Codification of Economic Substance Doctrine (sec. 452 of the bill and sec. 7701 of the Code)

PRESENT LAW

In general

The Code provides detailed rules specifying the computation of taxable income, including the amount, timing, source, and character of items of income, gain, loss, and deduction. These rules permit both taxpayers and the government to compute taxable income with reasonable accuracy and predictability. Taxpayers generally may plan their transactions in reliance on these rules to determine the federal income tax consequences arising from the transactions.

In addition to the statutory provisions, courts have developed several doctrines that can be applied to deny the tax benefits of a tax-motivated transaction, notwithstanding that the transaction may satisfy the literal requirements of a specific tax provision. These common-law doctrines are not entirely distinguishable, and their application to a given set of facts is often blurred by the courts, the IRS, and litigants. Although these doctrines serve an important role in the administration of the tax system, they can be seen as at odds with an objective, rule-based system of taxation.

One common-law doctrine applied over the years is the economic substance doctrine. In general, this doctrine denies tax benefits arising from transactions that do not result in a meaningful change to the taxpayer's economic position other than a purported reduction in federal income tax.[106]

Economic substance doctrine

Courts generally deny claimed tax benefits if the transaction that gives rise to those benefits lacks economic substance independent of U.S. federal income tax considerations—notwithstanding that the purported activity actually occurred. The Tax Court has described the doctrine as follows:

> The tax law . . . requires that the intended transactions have economic substance separate and distinct from economic benefit achieved solely by tax reduction. The doctrine of economic substance becomes applicable, and a judicial remedy is warranted, where a taxpayer seeks to claim

[106] *See, e.g., ACM Partnership v. Commissioner,* 157 F.3d 231 (3d Cir. 1998), *aff'g* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999); *Klamath Strategic Investment Fund, LLC v. United States,* 472 F. Supp. 2d 885 (E.D. Texas 2007), *aff'd* 568 F.3d 537 (5th Cir. 2009); *Coltec Industries, Inc. v. United States,* 454 F.3d 1340 (Fed. Cir. 2006), *vacating and remanding* 62 Fed. Cl. 716 (2004) (slip opinion at 123–124, 128); *cert. denied,* 127 S. Ct. 1261 (Mem.) (2007).

Closely related doctrines also applied by the courts (sometimes interchangeably with the economic substance doctrine) include the "sham transaction doctrine" and the "business purpose doctrine." *See, e.g., Knetsch v. United States,* 364 U.S. 361 (1960) (denying interest deductions on a "sham transaction" whose only purpose was to create the deductions). Certain "substance over form" cases involving tax-indifferent parties, in which courts have found that the substance of the transaction did not comport with the form asserted by the taxpayer, have also involved examination of whether the change in economic position that occurred, if any, was consistent with the form asserted, and whether the claimed business purpose supported the particular tax benefits that were claimed. *See, e.g., TIFD– III–E, Inc. v. United States,* 459 F.3d 220 (2d Cir. 2006); *BB&T Corporation v. United States,* 2007–1 USTC P 50,130 (M.D.N.C. 2007), *aff'd* 523 F.3d 461 (4th Cir. 2008).

tax benefits, unintended by Congress, by means of transactions that serve no economic purpose other than tax savings.[107]

Business purpose doctrine

A common law doctrine that often is considered together with the economic substance doctrine is the business purpose doctrine. The business purpose doctrine involves an inquiry into the subjective motives of the taxpayer—that is, whether the taxpayer intended the transaction to serve some useful non-tax purpose. In making this determination, some courts have bifurcated a transaction in which activities with non-tax objectives have been combined with unrelated activities having only tax-avoidance objectives, in order to disallow the tax benefits of the overall transaction.[108]

Application by the courts

Elements of the doctrine

There is a lack of uniformity regarding the proper application of the economic substance doctrine.[109] Some courts apply a conjunctive test that requires a taxpayer to establish the presence of both economic substance (i.e., the objective component) and business purpose (i.e., the subjective component) in order for the transaction to survive judicial scrutiny.[110] A narrower approach used by some courts is to conclude that either a business purpose or economic substance is sufficient to respect the transaction.[111] A third approach regards economic substance and business purpose as "simply more precise factors to consider" in determining whether a transaction has any practical economic effects other than the creation of tax benefits.[112]

One decision by the Court of Federal Claims questioned the continuing viability of the doctrine. That court also stated that "the use of the economic substance doctrine to trump mere compliance

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[107] *ACM Partnership v. Commissioner,* 73 T.C.M. at 2215.

[108] *See ACM Partnership v. Commissioner,* 157 F.3d at 256 n.48.

[109] "The casebooks are glutted with [economic substance] tests. Many such tests proliferate because they give the comforting illusion of consistency and precision. They often obscure rather than clarify." *Collins v. Commissioner,* 857 F.2d 1383, 1386 (9th Cir. 1988).

[110] See, e.g., *Pasternak v. Commissioner,* 990 F.2d 893, 898 (6th Cir. 1993) ("The threshold question is whether the transaction has economic substance. If the answer is yes, the question becomes whether the taxpayer was motivated by profit to participate in the transaction."). *See also, Klamath Strategic Investment Fund v. United States,* 568 F. 3d 537 (5th Cir. 2009) (even if taxpayers may have had a profit motive, a transaction was disregarded where it did not in fact have any realistic possibility of profit and funding was never at risk).

[111] See, e.g., *Rice's Toyota World v. Commissioner,* 752 F.2d 89, 91–92 (4th Cir. 1985) ("To treat a transaction as a sham, the court must find that the taxpayer was motivated by no business purposes other than obtaining tax benefits in entering the transaction, and, second, that the transaction has no economic substance because no reasonable possibility of a profit exists."); *IES Industries v. United States,* 253 F.3d 350, 358 (8th Cir. 2001) ("In determining whether a transaction is a sham for tax purposes [under the Eighth Circuit test], a transaction will be characterized as a sham if it is not motivated by any economic purpose out of tax considerations (the business purpose test), and if it is without economic substance because no real potential for profit exists (the economic substance test)."). As noted earlier, the economic substance doctrine and the sham transaction doctrine are similar and sometimes are applied interchangeably. For a more detailed discussion of the sham transaction doctrine, see, e.g., Joint Committee on Taxation, *Study of Present-Law Penalty and Interest Provisions as Required by Section 3801 of the Internal Revenue Service Restructuring and Reform Act of 1998 (including Provisions Relating to Corporate Tax Shelters)* (JCS–3–99) at 182.

[112] See, e.g., *ACM Partnership v. Commissioner,* 157 F.3d at 247; *James v. Commissioner,* 899 F.2d 905, 908 (10th Cir. 1995); *Sacks v. Commissioner,* 69 F.3d 982, 985 (9th Cir. 1995) ("Instead, the consideration of business purpose and economic substance are simply more precise factors to consider . . . We have repeatedly and carefully noted that this formulation cannot be used as a 'rigid two-step analysis'.")

with the Code would violate the separation of powers" though that court also found that the particular transaction at issue in the case did not lack economic substance. The Court of Appeals for the Federal Circuit ("Federal Circuit Court") overruled the Court of Federal Claims decision, reiterating the viability of the economic substance doctrine and concluding that the transaction in question violated that doctrine.[113] The Federal Circuit Court stated that "[w]hile the doctrine may well also apply if the taxpayer's sole subjective motivation is tax avoidance even if the transaction has economic substance, [footnote omitted], a lack of economic substance is sufficient to disqualify the transaction without proof that the taxpayer's sole motive is tax avoidance."[114]

Nontax economic benefits

There also is a lack of uniformity regarding the type of non-tax economic benefit a taxpayer must establish in order to demonstrate that a transaction has economic substance. Some courts have denied tax benefits on the grounds that a stated business benefit of a particular structure was not in fact obtained by that structure.[115] Several courts have denied tax benefits on the grounds that the subject transactions lacked profit potentia1.[116] In addition, some courts have applied the economic substance doctrine to disallow tax benefits in transactions in which a taxpayer was exposed to risk and the transaction had a profit potential, but the court concluded that the economic risks and profit potential were insignificant when compared to the tax benefits.[117] Under this analysis, the taxpayer's profit potential must be more than nominal. Conversely, other courts view the application of the economic substance doctrine as requiring an objective determination of whether a "reasonable possibility of profit" from the transaction existed apart from the tax benefits.[118] In these cases, in assessing whether a reasonable possibility of profit exists, it may be sufficient if there is a

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[113] *Coltec Industries, Inc. v. United States,* 62 Fed. Cl. 716 (2004) (slip opinion at 123–124, 128); *vacated and remanded,* 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied,* 127 S. Ct. 1261 (Mem.) (2007).

[114] The Federal Circuit Court stated that "when the taxpayer claims a deduction, it is the taxpayer who bears the burden of proving that the transaction has economic substance." The Federal Circuit Court quoted a decision of its predecessor court, stating that "*Gregory v. Helvering* requires that a taxpayer carry an unusually heavy burden when he attempts to demonstrate that Congress intended to give favorable tax treatment to the kind of transaction that would never occur absent the motive of tax avoidance." The Court also stated that "while the taxpayer's subjective motivation may be pertinent to the existence of a tax avoidance purpose, all courts have looked to the objective reality of a transaction in assessing its economic substance." *Coltec Industries, Inc. v. United States,* 454 F.3d at 1355, 1356.

[115] *See, e.g., Coltec Industries v. United States,* 454 F.3d 1340 (Fed. Cir. 2006). The court analyzed the transfer to a subsidiary of a note purporting to provide high stock basis in exchange for a purported assumption of liabilities, and held these transactions unnecessary to accomplish any business purpose of using a subsidiary to manage asbestos liabilities. The court also held that the purported business purpose of adding a barrier to veil-piercing claims by third parties was not accomplished by the transaction. 454 F.3d at 1358–1360 (Fed. Cir. 2006).

[116] *See, e.g., Knetsch,* 364 U.S. at 361; *Goldstein v. Commissioner,* 364 F.2d 734 (2d Cir. 1966) (holding that an unprofitable, leveraged acquisition of Treasury bills, and accompanying prepaid interest deduction, lacked economic substance).

[117] *See, e.g., Goldstein v. Commissioner,* 364 F.2d at 739–40 (disallowing deduction even though taxpayer had a possibility of small gain or loss by owning Treasury bills); Sheldon v. Commissioner, 94 T.C. 738, 768 (1990) (stating that "potential for gain . . . is infinitesimally nominal and vastly insignificant when considered in comparison with the claimed deductions").

[118] *See, e.g., Rice's Toyota World v. Commissioner,* 752 F. 2d 89, 94 (4th Cir. 1985) (the economic substance inquiry requires an objective determination of whether a reasonable possibility of profit from the transaction existed apart from tax benefits); *Compaq Computer Corp. v. Commissioner,* 277 F.3d 778, 781 (5th Cir. 2001) (applied the same test, citing *Rice's Toyota World*); *IES Industries v. United States,* 253 F.3d 350, 354 (8th Cir. 2001).

nominal amount of pre-tax profit as measured against expected tax benefits.

Financial accounting benefits

In determining whether a taxpayer had a valid business purpose for entering into a transaction, at least one court has concluded that financial accounting benefits arising from tax savings do not qualify as a non-tax business purpose.[119] However, based on court decisions that recognize the importance of financial accounting treatment, taxpayers have asserted that financial accounting benefits arising from tax savings can satisfy the business purpose test.[120]

Tax-indifferent parties

A number of cases have involved transactions structured to allocate income for Federal tax purposes to a tax-indifferent party, with a corresponding deduction, or favorable basis result, to a taxable person. The income allocated to the tax-indifferent party for tax purposes was structured to exceed any actual economic income to be received by the tax indifferent party from the transaction. Courts have sometimes concluded that a particular type of transaction did not satisfy the economic substance doctrine.[121] In other cases, courts have indicated that the substance of a transaction did not support the form of income allocations asserted by the taxpayer and have questioned whether asserted business purpose or other standards were met.[122]

REASONS FOR CHANCE

Tax avoidance transactions have relied upon the interaction of highly technical tax law provisions to produce tax consequences not contemplated by Congress. When successful, taxpayers who engage in these transactions enlarge the tax gap by gaining unintended tax relief and by undermining the overall integrity of the tax system.

A strictly rule-based tax system cannot efficiently prescribe the appropriate outcome of every conceivable transaction that might be devised and is, as a result, incapable of preventing all unintended consequences. Thus, many courts have long recognized the need to supplement tax rules with anti-tax-avoidance standards, such as the economic substance doctrine, in order to assure the Congressional purpose is achieved. The Committee recognizes that the IRS has achieved a number of recent successes in litigation. The Committee believes it is still desirable to provide greater clarity and uniformity in the application of the economic substance doctrine in order to improve its effectiveness at deterring unintended consequences.

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[119] *See American Electric Power, Inc. v. United States,* 136 F. Supp. 2d 762, 791–92 (S.D. Ohio 2001), aff'd, 326 F.3d.737 (6th Cir. 2003).

[120] See, e.g., Joint Committee on Taxation, *Report of Investigation of Enron Corporation and Related Entities Regarding Federal Tax and Compensation Issues, and Policy Recommendations* (JCX–3–03) February, 2003 ("Enron Report"), Volume III at C–93, 289. Enron Corporation relied on *Frank Lyon Co. v. United States,* 435 U.S. 561, 577–78 (1978), and *Newman v. Commissioner,* 902 F.2d 159, 163 (2d Cir. 1990), to argue that financial accounting benefits arising from tax savings constitute a good business purpose.

[121] *See, e.g., ACM Partnership v. Commissioner,* 157 F.3d 231 (3d Cir. 1998), *aff'g* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999).

[122] *See, e.g., TIFD-III-E, Inc. v. United States,* 459 F.3d 220 (2d Cir. 2006).

EXPLANATION OF PROVISION

The provision clarifies and enhances the application of the economic substance doctrine. Under the provision, in the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if (1) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and (2) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.[123] The provision provides a uniform definition of economic substance, but does not alter the flexibility of the courts in other respects.

The determination of whether the economic substance doctrine is relevant to a transaction shall be made in the same manner as if the provision had never been enacted. Thus, the provision does not change current law standards in determining when to utilize an economic substance analysis.[124]

The provision is not intended to alter the tax treatment of certain basic business transactions that, under longstanding judicial and administrative practice are respected, merely because the choice between meaningful economic alternatives is largely or entirely based on comparative tax advantages. Among[125] these basic transactions are (1) the choice between capitalizing a business enterprise with debt or equity;[126] (2) a U.S. person's choice between utilizing a foreign corporation or a domestic corporation to make a foreign investment;[127] (3) the choice to enter a transaction or series of transactions that constitute a corporate organization or reorganization under subchapter C;[128] and (4) the choice to utilize a related-party entity in a transaction, provided that the arm's length standard of section 482 and other applicable concepts are satisfied.[129] Leasing transactions, like all other types of transactions, will continue to be analyzed in light of all the facts and circumstances.[130] As under present law, whether a particular transaction meets the requirements for specific treatment under any of

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[123] In applying these tests, any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

[124] If the tax benefits are clearly consistent with all applicable provisions of the Code and the purposes of such provisions, it is not intended that such tax benefits be disallowed if the only reason for such disallowance is that the transaction fails the economic substance doctrine as defined in this provision. *See, e.g.,* Treas. Reg. sec. 1.269–2, stating that characteristic of circumstances in which a deduction otherwise allowed will be disallowed are those in which the effect of the deduction, credit, or other allowance would be to distort the liability of the particular taxpayer when the essential nature of the transaction or situation is examined in the light of the basic purpose or plan which the deduction, credit, or other allowance was designed by the Congress to effectuate.

[125] The examples are illustrative and not exclusive.

[126] See, e.g., *John Kelley Co. v. Commissioner,* 326 U.S. 521 (1946) (respecting debt characterization in one case and not in the other, based on all the facts and circumstances).

[127] See, e.g., *Sam Siegel v. Commissioner,* 45. T.C. 566 (1966), acq. 1966–2 C.B. 3. *But see Commissioner v. Bollinger,* 485 U.S. 340 (1988) (agency principles applied to title-holding corporation under the facts and circumstances).

[128] See, e.g., *Rev. Proc. 2009–3 2009–11R.B. 108, Secs. 3.01(38), (39), and (41)* (IRS will not rule on certain matters relating to incorporations or reorganizations unless there is a "significant issue"); *compare Gregory v. Helvering,* 293 U.S. 465 (1935).

[129] See, e.g., *National Carbide v. Commissioner,* 336 U.S. 422 (1949), *Moline Properties v. Commissioner,* 319 U.S. 435 (1943); *compare, e.g. Aiken Industries, Inc. v. Commissioner,* 56 T.C. 925 (1971), acq., 19722 C.B. 1; *Commissioner v. Bollinger,* 485 U.S. 340 (1988); *see also* sec. 7701(1).

[130] *See, e.g., Frank Lyon v. Commissioner,* 435 U.S. 561 (1978); *Hilton v. Commissioner,* 74 T.C. 305, *aff'd,* 671 F. 2d 316 (9th Cir. 1982), *cert. denied,* 459 U.S. 907 (1982); *Coltec Industries v. United States,* 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied,* 127 S. Ct. 1261 (Mem.) (2007); *BB&T Corporation v. United States,* 2007–1 USTC P 50,130 (M.D.N.C. 2007), *aff'd,* 523 F.3d 461 (4th Cir. 2008).

these provisions can be a question of facts and circumstances. Also, the fact that a transaction does meet the requirements for specific treatment under any provision of the Code is not determinative of whether a transaction or series of transactions of which it is a part has economic substance.[131]

The provision does not alter the court's ability to aggregate, disaggregate, or otherwise recharacterize a transaction when applying the doctrine. For example, the provision reiterates the present-law ability of the courts to bifurcate a transaction in which independent activities with non-tax objectives are combined with an unrelated item having only tax-avoidance objectives in order to disallow those tax-motivated benefits.[132]

Conjunctive analysis

The provision clarifies that the economic substance doctrine involves a conjunctive analysis—there must be an inquiry regarding the objective effects of the transaction on the taxpayer's economic position as well as an inquiry regarding the taxpayer's subjective motives for engaging in the transaction. Under the provision, a transaction must satisfy both tests, i.e., the transaction must change in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and the taxpayer must have a substantial non-Federal-income-tax purpose[133] for entering into such transaction, in order to satisfy the economic substance doctrine. This clarification eliminates the disparity that exists among the Federal circuit courts regarding the application of the doctrine, and modifies its application in those circuits in which either a change in economic position or a non-tax business purpose (without having both) is sufficient to satisfy the economic substance doctrine.[134]

Non-Federal-tax business purpose

Under the provision, a taxpayer's non-Federal-income-tax purpose for entering into a transaction (the second prong in the anal-

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[131] As examples of cases in which courts have found that a transaction does not meet the requirements for the treatment claimed by the taxpayer under the Code, or does not have economic substance, *see e.g., TIFD- III-E, Inc. v. United States,* 459 F.3d 220 (2d Cir. 2006); *BB&T Corporation v. United States,* 2007–1 USTC P 50,130 (M.D.N.C. 2007) *aff'd,* 523 F.3d 461 (4th Cir. 2008); *Tribune Company and Subsidiaries v. Commissioner,* 125 T.C. 110 (2005); *H.J. Heinz Company and Subsidiaries v. United States,* 76 Fed. Cl. 570 (2007); *Coltec Industries, Inc. v. United States,* 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied* 127 S. Ct. 1261 (Mem.) (2007); *Long Term Capital Holdings LP v. United States,* 330 F. Supp. 2d 122 (D. Conn. 2004), *aff'd,* 150 Fed. Appx. 40 (2d Cir. 2005); *Klamath Strategic Investment Fund, LLC v. United States,* 472 F. Supp. 2d 885 (E.D. Texas 2007); *aff'd,* 568 F.3D 537 (5th Cir. 2009); *Santa Monica Pictures LLC v. Commissioner,* 89 T.C.M. 1157 (2005).

[132] See, e.g., Coltec Industries, Inc. v. United States, 454 F.3d 1340 (Fed. Cir. 2006), cert. denied 127 S. Ct. 1261 (Mem.) (2007) ("the first asserted business purpose focuses on the wrong transaction—the creation of Garrison as a separate subsidiary to manage asbestos liabilities. . . . [W]e must focus on the transaction that gave the taxpayer a high basis in the stock and thus gave rise to the alleged benefit upon sale...") 454 F.3d 1340, 1358 (Fed. Cir. 2006). See also ACM Partnership v. Commissioner, 157 F.3d at 256 n.48; Minnesota Tea Co. v. Helvering, 302 U.S. 609, 613 (1938) ("A given result at the end of a straight path is not made a different result because reached by following a devious path.").

[133] For purposes of these tests, any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

[134] The provision defines "economic substance doctrine" as the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose. Thus, the definition includes any doctrine that denies tax benefits for lack of economic substance, for lack of business purpose, or for lack of both.

ysis) must be substantial.[135] For purposes of this analysis, any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect. Also, a purpose of achieving a favorable accounting treatment for financial reporting purposes shall not be taken into account as a non-Federal-income-tax purpose if the origin of such financial accounting benefit is a reduction of Federal income tax.[136]

Profit potential

Under the provision, a taxpayer may rely on factors other than profit potential to demonstrate that a transaction results in a meaningful change in the taxpayer's economic position or that the taxpayer has a substantial non-Federal-tax purpose for entering into such transaction. The provision does not require or establish a specified minimum return that will satisfy the profit potential test. However, if a taxpayer relies on a profit potential, the present value of the reasonably expected pre-tax profit must be substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.[137] Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit.

Personal transactions of individuals

In the case of an individual, the provision applies only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

Other rules

The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of the provision.

No inference is intended as to the proper application of the economic substance doctrine under present law. In addition, the provision shall not be construed as alter or supplanting any other rule of law, including any common-law doctrine or provision of the Code or regulations or other guidance thereunder; and the provision shall be construed as being additive to any such other rule of law.

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[135] See, e.g., Treas. Reg. sec. 1.269–2(b) (stating that a distortion of tax liability indicating the principal purpose of tax evasion or avoidance might be evidenced by the fact that "the transaction was not undertaken for reasons germane to the conduct of the business of the taxpayer"). Similarly, in ACM Partnership v. Commissioner, 73 T.C.M. (CCH) 2189 (1997), the court stated:

Key to [the determination of whether a transaction has economic substance] is that the transaction must be rationally related to a useful nontax purpose that is plausible in light of the taxpayer's conduct and useful in light of the taxpayer's economic situation and intentions. Both the utility of the stated purpose and the rationality of the means chosen to effectuate it must be evaluated in accordance with commercial practices in the relevant industry. A rational relationship between purpose and means ordinarily will not be found unless there was a reasonable expectation that the nontax benefits would be at least commensurate with the transaction costs. [Citations omitted.]

[136] Claiming that a financial accounting benefit constitutes a substantial non-tax purpose fails to consider the origin of the accounting benefit (i.e., reduction of taxes) and significantly diminishes the purpose for having a substantial non-tax purpose requirement. See, e.g., American Electric Power, Inc. v. United States, 136 F. Supp. 2d 762, 791–92 (S.D. Ohio 2001) ("AEP's intended use of the cash flows generated by the [corporate-owned life insurance] plan is irrelevant to the subjective prong of the economic substance analysis. If a legitimate business purpose for the use of the tax savings 'were sufficient to breathe substance into a transaction whose only purpose was to reduce taxes, [then] every sham tax-shelter device might succeed,'. . .") (citing Winn-Dixie v. Commissioner, 113 T.C. 254, 287 (1999)); aff'd, 326 Fad 737 (6th Cir. 2003).

[137] Thus, a "reasonable possibility of profit" alone will not be sufficient to establish that a transaction has economic substance.

EFFECTIVE DATE

The provision applies to transactions entered into after the date of enactment.

K. Penalties for Underpayments Attributable to Transactions Lacking Economic Substance (sec. 453 of the bill and sec. 6662 and sec. 6664 of the Code)

PRESENT LAW

General accuracy-related penalty

An accuracy-related penalty under section 6662 applies to the portion of any underpayment that is attributable to (1) negligence, (2) any substantial understatement of income tax, (3) any substantial valuation misstatement, (4) any substantial overstatement of pension liabilities, or (5) any substantial estate or gift tax valuation understatement. If the correct income tax liability exceeds that reported by the taxpayer by the greater of 10 percent of the correct tax or $5,000 (or, in the case of corporations, by the lesser of (a) 10 percent of the correct tax (or $10,000 if greater) or (b) $10 million), then a substantial understatement exists and a penalty may be imposed equal to 20 percent of the underpayment of tax attributable to the understatement.[138] Except in the case of tax shelters,[139] the amount of any understatement is reduced by any portion attributable to an item if (1) the treatment of the item is supported by substantial authority, or (2) facts relevant to the tax treatment of the item were adequately disclosed and there was a reasonable basis for its tax treatment. The Treasury Secretary may prescribe a list of positions which the Secretary believes do not meet the requirements for substantial authority under this provision.

The section 6662 penalty generally is abated (even with respect to tax shelters) in cases in which the taxpayer can demonstrate that there was "reasonable cause" for the underpayment and that the taxpayer acted in good faith.[140] The relevant regulations for a tax shelter provide that reasonable cause exists where the taxpayer "reasonably relies in good faith on an opinion based on a professional tax advisor's analysis of the pertinent facts and authorities [that] . . . unambiguously concludes that there is a greater than 50-percent likelihood that the tax treatment of the item will be upheld if challenged" by the IRS.[141] For transactions other than tax shelters, the relevant regulations provide a facts and circumstances test, the most important factor generally being the extent of the taxpayer's effort to assess the proper tax liability. If a taxpayer relies on an opinion, reliance is not reasonable if the taxpayer knows or should have known that the advisor lacked knowledge in the relevant aspects of Federal tax law, or if the taxpayer fails to disclose a fact that it knows or should have known is rel-

[138] Sec. 6662.

[139] A tax shelter is defined for this purpose as a partnership or other entity, an investment plan or arrangement, or any other plan or arrangement if a significant purpose of such partnership, other entity, plan, or arrangement is the avoidance or evasion of Federal income tax. Sec. 6662(d)(2)(C).

[140] Sec. 6664(c).

[141] Treas. Reg. sec. 1.6662–4(g)(4)(i)(B); Treas. Reg. sec. 1.6664–4(c).

evant. Certain additional requirements apply with respect to the advice.[142]

Listed transactions and reportable avoidance transactions

In general

A separate accuracy-related penalty under section 6662A applies to any listed transaction and to any other reportable transaction that is not a listed transaction, if a significant purpose of such transaction is the avoidance or evasion of Federal income tax[143] ("reportable avoidance transaction"). The penalty rate and defenses available to avoid the penalty vary depending on whether the transaction was adequately disclosed.

Both listed transactions and other reportable transactions are allowed to be described by the Treasury Department under section 6011 as transactions that must be reported, and section 6707A(c) imposes a penalty for failure to adequately report such transactions under section 6011. A reportable transaction is defined as one that the Treasury Secretary determines is required to be disclosed because it is determined to have a potential for tax avoidance or evasion.[144] A listed transaction is defined as a reportable transaction which is the same as, or substantially similar to, a transaction specifically identified by the Secretary as a tax avoidance transaction for purposes of the reporting disclosure requirements.[145]

Disclosed transactions

In general, a 20-percent accuracy-related penalty is imposed on any understatement attributable to an adequately disclosed listed transaction or reportable avoidance transaction.[146] The only exception to the penalty is if the taxpayer satisfies a more stringent reasonable cause and good faith exception ("strengthened reasonable cause exception"), which is described below. The strengthened reasonable cause exception is available only if the relevant facts affecting the tax treatment were adequately disclosed, there is or was substantial authority for the claimed tax treatment, and the taxpayer reasonably believed that the claimed tax treatment was more likely than not the proper treatment. A reasonable belief must be based on the facts and law as they exist at the time that the return in question is filed, and not take into account the possibility that a return would not be audited. Moreover, reliance on professional

[142] See Treas. Reg. Sec. 1.6664–4(c). In addition to the requirements applicable to taxpayers under the regulations, advisors may be subject to potential penalties under section 6694 (applicable to return preparers), and to monetary penalties and other sanctions under Circular 230 (which provides rules governing persons practicing before the IRS). Under Circular 230, if a transaction is a "covered transaction" (a term that includes listed transactions and certain nonlisted reportable transactions) a "more likely than not" confidence level is required for written tax advice that may be relied upon by a taxpayer for the purpose of avoiding penalties, and certain other standards must also be met. Treasury Dept. Circular 230 (Rev. 4–2008) Sec. 10.35. For other tax advice, Circular 230 generally requires a lower "realistic possibility" confidence level or a "non-frivolous" confidence level coupled with advising the client of any opportunity to avoid the accuracy related penalty under section 6662 by adequate disclosure. Treasury Dept. Circular 230 (Rev. 4–2008) Sec. 10.34.

[143] Sec. 6662A(b)(2).

[144] Sec. 6707A(c)(1).

[145] Sec. 6707A(c)(2).

[146] Sec. 6662A(a).

advice may support a reasonable belief only in certain circumstances.[147]

Undisclosed transactions

If the taxpayer does not adequately disclose the transaction, the strengthened-reasonable-cause exception is not available (i.e., a strict-liability penalty generally applies), and the taxpayer is subject to an increased penalty equal to 30 percent of the understatement.[148] However, a taxpayer will be treated as having adequately disclosed a transaction for this purpose if the IRS Commissioner has separately rescinded the separate penalty under section 6707A for failure to disclose a reportable transaction.[149] The IRS Commissioner is authorized to do this only if the failure does not relate to a listed transaction and only if rescinding the penalty would promote compliance and effective tax administration.[150]

A public entity that is required to pay a penalty for an undisclosed listed or reportable transaction must disclose the imposition of the penalty in reports to the SEC for such periods as the Secretary shall specify. The disclosure to the SEC applies without regard to whether the taxpayer determines the amount of the penalty to be material to the reports in which the penalty must appear, and any failure to disclose such penalty in the reports is treated as a failure to disclose a listed transaction. A taxpayer must disclose a penalty in reports to the SEC once the taxpayer has exhausted its administrative and judicial remedies with respect to the penalty (or if earlier, when paid).[151]

Determination of the understatement amount

The penalty is applied to the amount of any understatement attributable to the listed or reportable avoidance transaction without regard to other items on the tax return. For purposes of this provision, the amount of the understatement is determined as the sum of: (1) the product of the highest corporate or individual tax rate (as appropriate) and the increase in taxable income resulting from the difference between the taxpayer's treatment of the item and the proper treatment of the item (without regard to other items on the tax return);[152] and (2) the amount of any decrease in the aggregate amount of credits which results from a difference between the taxpayer's treatment of an item and the proper tax treatment of such item.

Except as provided in regulations, a taxpayer's treatment of an item shall not take into account any amendment or supplement to a return if the amendment or supplement is filed after the earlier of when the taxpayer is first contacted regarding an examination of the return or such other date as specified by the Secretary.[153]

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[147] Section 6664(d)(3)(B) would not allow a reasonable belief to be based on a "disqualified opinion" or on an opinion from a "disqualified tax advisor".

[148] Sec. 6662A(c).

[149] Sec. 6664(d).

[150] Sec. 6707A(d).

[151] Sec. 6707A(e).

[152] For this purpose, any reduction in the excess of deductions allowed for the taxable year over gross income for such year, and any reduction in the amount of capital losses which would (without regard to section 1211) be allowed for such year, shall be treated as an increase in taxable income. Sec. 6662A(b).

[153] Sec. 6662A(e)(3).

Strengthened reasonable cause exception

A penalty is not imposed under section 6662A with respect to any portion of an understatement if it is shown that there was reasonable cause for such portion and the taxpayer acted in good faith. Such a showing requires: (1) adequate disclosure of the facts affecting the transaction in accordance with the regulations under section 6011;[154] (2) that there is or was substantial authority for such treatment; and (3) that the taxpayer reasonably believed that such treatment was more likely than not the proper treatment. For this purpose, a taxpayer will be treated as having a reasonable belief with respect to the tax treatment of an item only if such belief: (1) is based on the facts and law that exist at the time the tax return (that includes the item) is filed; and (2) relates solely to the taxpayer's chances of success on the merits and does not take into account the possibility that (a) a return will not be audited, (b) the treatment will not be raised on audit, or (c) the treatment will be resolved through settlement if raised.[155]

A taxpayer may (but is not required to) rely on an opinion of a tax advisor in establishing its reasonable belief with respect to the tax treatment of the item. However, a taxpayer may not rely on an opinion of a tax advisor for this purpose if the opinion (1) is provided by a disqualified tax advisor or (2) is a disqualified opinion.

Disqualified tax advisor

A disqualified tax advisor is any advisor who: (1) is a material advisor[156] and who participates in the organization, management, promotion, or sale of the transaction or is related (within the meaning of section 267(b) or 707(b)(1)) to any person who so participates; (2) is compensated directly or indirectly[157] by a material advisor with respect to the transaction; (3) has a fee arrangement with respect to the transaction that is contingent on all or part of the intended tax benefits from the transaction being sustained; or (4) as determined under regulations prescribed by the Secretary, has a disqualifying financial interest with respect to the transaction.

A material advisor is considered as participating in the organization of a transaction if the advisor performs acts relating to the development of the transaction. This may include, for example, preparing documents: (1) establishing a structure used in connection with the transaction (such as a partnership agreement); (2) describing the transaction (such as an offering memorandum or other statement describing the transaction); or (3) relating to the registration of the transaction with any Federal, State, or local government body.[158] Participation in the management of a transaction

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[154] See the previous discussion regarding the penalty for failing to disclose a reportable transaction.

[155] Sec. 6664(d).

[156] The term "material advisor" means any person who provides any material aid, assistance, or advice with respect to organizing, managing, promoting, selling, implementing, or carrying out any reportable transaction, and who derives gross income in excess of $50,000 in the case of a reportable transaction substantially all of the tax benefits from which are provided to natural persons ($250,000 in any other case). Sec. 6111(b)(1).

[157] This situation could arise, for example, when an advisor has an arrangement or understanding (oral or written) with an organizer, manager, or promoter of a reportable transaction that such party will recommend or refer potential participants to the advisor for an opinion regarding the tax treatment of the transaction.

[158] An advisor should not be treated as participating in the organization of a transaction if the advisor's only involvement with respect to the organization of the transaction is the ren-

Continued

means involvement in the decision-making process regarding any business activity with respect to the transaction. Participation in the promotion or sale of a transaction means involvement in the marketing or solicitation of the transaction to others. Thus, an advisor who provides information about the transaction to a potential participant is involved in the promotion or sale of a transaction, as is any advisor who recommends the transaction to a potential participant.

Disqualified opinion

An opinion may not be relied upon if the opinion: (1) is based on unreasonable factual or legal assumptions (including assumptions as to future events); (2) unreasonably relies upon representations, statements, finding or agreements of the taxpayer or any other person; (3) does not identify and consider all relevant facts; or (4) fails to meet any other requirement prescribed by the Secretary.

Coordination with other penalties

To the extent a penalty on an understatement is imposed under section 6662A, that same amount of understatement is not also subject to the accuracy-related penalty under section 6662(a) or to the valuation misstatement penalties under section 6662(e) or 6662(h). However, such amount of understatement is included for purposes of determining whether any understatement (as defined in section 6662(d)(2)) is a substantial understatement as defined under section 6662(d)(1) and for purposes of identifying an underpayment under the section 6663 fraud penalty.

The penalty imposed under section 6662A does not apply to any portion of an understatement to which a fraud penalty is applied under section 6663.

Erroneous claim for refund or credit

If a claim for refund or credit with respect to income tax (other than a claim relating to the earned income tax credit) is made for an excessive amount, unless it is shown that the claim for such excessive amount has a reasonable basis, the person making such claim is subject to a penalty in an amount equal to 20 percent of the excessive amount.[159]

The term "excessive amount" means the amount by which the amount of the claim for refund for any taxable year exceeds the amount of such claim allowable for the taxable year.

This penalty does not apply to any portion of the excessive amount of a claim for refund or credit which is subject to a penalty imposed under the accuracy related or fraud penalty provisions (including the general accuracy related penalty, or the penalty with respect to listed and reportable transactions, described above).

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dering of an opinion regarding the tax consequences of such transaction. However, such an advisor may be a "disqualified tax advisor" with respect to the transaction if the advisor participates in the management, promotion, or sale of the transaction (or if the advisor is compensated by a material advisor, has a fee arrangement that is contingent on the tax benefits of the transaction, or as determined by the Secretary, has a continuing financial interest with respect to the transaction). See Notice 2005–12, 2005–1 C.B. 494 regarding disqualified compensation arrangements.

[159] Sec. 6676.

REASONS FOR CHANGE

The Committee believes that a stronger penalty under section 6662 should be imposed on understatements attributable to non-economic substance and similar transactions, to improve compliance by deterring taxpayers from entering such transactions. The Committee is concerned that under present law there is a potential to avoid penalties in such cases (based for example on certain levels of tax advice), and that the potential that a taxpayer in such cases may pay only the tax due plus interest is not a sufficient deterrent. The Committee therefore believes it is appropriate to impose a new strict liability penalty in such cases. The Committee also believes that a similar strict liability standard should apply to tax shelter transactions.

In addition, the Committee believes that for large corporations, and for persons required to file reports under section 13 of the Securities Exchange Act of 1934, any position for which a reasonable cause and good faith defense to penalties is still available should satisfy a confidence level of being at least more likely than not to prevail, and the same level of confidence should be required of such taxpayers in determining whether there is a substantial understatement of income tax.

EXPLANATION OF PROVISION

The provision imposes a new, stronger penalty under section 6662 for an understatement attributable to any disallowance of claimed tax benefits by reason of a transaction lacking economic substance, as defined in new section 7701(p),[160] or failing to meet the requirements of any similar rule of law.[161] The penalty rate is 20 percent (increased to 40 percent if the taxpayer does not adequately disclose the relevant facts affecting the tax treatment in the return or a statement attached to the return). Except as provided in regulations, an amended return or supplement to a return is not taken into account if filed after the taxpayer has been contacted for audit or such other date as is specified by the Secretary. No exceptions (including the reasonable cause rules) to the penalty are available (i.e., the penalty is a strict-liability penalty). Thus, under the provision, outside opinions or in-house analysis would not protect a taxpayer from imposition of a penalty if it is determined that the transaction lacks economic substance or fails to meet the requirements of any similar rule of law. Similarly, a claim for refund that is excessive under section 6676 due to a claim that is lacking in economic substance or failing to meet the requirements of any similar rule of law is subject to the 20 percent penalty under that section, and the reasonable basis exception is not available.

[160] That provision generally provides that in any case in which a court determines that the economic substance doctrine is relevant, a transaction has economic substance only if: (1) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and (2) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction. Specific other rules also apply. See "Explanation of Provision" for the immediately preceding provision, "Codification of the economic substance doctrine.".

[161] For example, the penalty would apply to a transaction that is disregarded as a result of the application of the same factors and analysis that is required under the provision for an economic substance analysis, even if a different term is used to describe the doctrine.

The penalty does not apply to any portion of an underpayment on which a fraud penalty is imposed.[162] The new 20-percent penalty (and 40-percent penalty for nondisclosed transactions) is also added to the penalties to which section 6662A will not also apply.[163]

As described above, under the provision, the reasonable cause and good faith exception of present law section 6664(c)(1) does not apply to any portion of an underpayment which is attributable to a transaction lacking economic substance, as defined in section 7701(p), or failing to meet the requirements of any similar rule of law, or to any tax shelter (as defined in present law section 6662(d)(2)(C)). In addition, the reasonable cause and good faith exception of present law section 6664(c)(1) also does not apply to any underpayment in which the taxpayer is a specified person. A specified person is defined as (i) any person required to file periodic or other reports under section 13 of the Securities and Exchange Act of 1934, and (ii) any corporation with gross receipts in excess of $100 million for the taxable year involved.[164]

In the case of a substantial understatement of income tax (which is a separate type of understatement under new section 6662(b) than an understatement attributable to a transaction lacking economic substance or failing to meet the requirements of any similar rule of law),[165] the rules of section 6662(d) still apply, but are changed in the case of a specified person (as defined above). In the case of such a person, it is no longer the case that a substantial understatement is reduced if there is or was substantial authority for the taxpayer's treatment, or if the relevant facts were disclosed and there is a reasonable basis for the taxpayer's tax treatment. Under the provision, a substantial understatement of a specified person can be reduced only by that portion attributable to any item with respect to which the taxpayer had a reasonable belief that the tax treatment by the taxpayer is more likely than not the proper treatment.

EFFECTIVE DATE

The provision applies to transactions entered into after the date of enactment.

L. Certain Health Related Benefits Applicable to Spouses and Dependents Extended to Eligible Designated Beneficiaries (sec. 461 of the bill and secs. 105, 106, 162, 501, 3121, 3306, and 3401 of the Code)

PRESENT LAW

Definition of dependent for exclusion for employer-provided health coverage

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-pro-

[162] I.e., section 6662(b) of present law applies to the new penalty as well.

[163] As under present law, the penalties under section 6662 (including the new penalty) do not apply to any portion of an underpayment on which a fraud penalty is imposed.

[164] For purposes of this rule, all persons treated as a single employer under section 52(a) are treated as one person.

[165] The rules and exceptions of section 6662(d) do not apply to any understatement attributable to a transaction that lacks economic substance or fails to meet the requirements of any similar rule of law.

vided health coverage for employees, their spouses, and their dependents under an accident or health plan.[166] In addition, any reimbursements under the accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.[167] For purposes of these exclusions, dependents are determined under section 152, but without regard to section 152(b)(1), (b)(2), and (d)(1)(B). Section 152 defines a dependent as a qualifying child or qualifying relative.

Under section 152(c), a child generally is a qualifying child of a taxpayer if the child satisfies each of five tests for the taxable year: (1) the child has the same principal place of abode as the taxpayer for more than one-half of the taxable year; (2) the child has a specified relationship to the taxpayer; (3) the child has not yet attained a specified age; (4) the child has not provided over one-half of their own support for the calendar year in which the taxable year of the taxpayer begins; and (5) the qualifying child has not filed a joint return (other than for a claim of refund) with their spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins. A tie-breaking rule applies if more than one taxpayer claims a child as a qualifying child. The specified relationship is that the child is the taxpayer's son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, or a descendant of any such individual. With respect to the specified age, a child must be under age 19 (or under age 24 in the case of a full-time student). However, no age limit applies with respect to individuals who are totally and permanently disabled within the meaning of section 22(e)(3) at any time during the calendar year. Other rules may apply.

Under section 152(d) a qualifying relative means an individual that satisfies four tests for the taxable year: (1) the individual bears a specified relationship to the taxpayer; (2) the individual's gross income for the calendar year in which such taxable year begins is less than the exemption amount under section 151(d);[168] (3) the taxpayer provides more than one-half the individual's support for the calendar year in which the taxable year begins; and (4) the individual is not a qualifying child of the taxpayer—or any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins. The specified relationship test for a qualifying relative is satisfied if that individual is the taxpayer's: (1) child or descendant of a child; (2) brother, sister, stepbrother or stepsister; (3) father, mother or ancestor of either; (4) stepfather or stepmother; (5) niece or nephew; (6) aunt or uncle; (7) in-law; or (8) certain other individuals, who for the taxable year of the taxpayer, have the same principal place of abode as the taxpayer and are members of the taxpayer's household.[169]

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements

[166] Sec. 106 and proposed Treas. Reg. sec. 1.106–1.

[167] Sec. 105(b).

[168] This requirement is provide in section 152(d)(l)(B) and thus is disregarded for purposes of determining whether an individual is a taxpayer's dependent for purposes of the exclusions for employer-provided health coverage.

[169] Generally, same-sex partners do not qualify as dependents under section 152. In addition, same-sex partners are not recognized as spouses for purposes of the Code. Defense of Marriage Act, Pub. L. No. 104–199.

which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The same definition of dependent applies for purposes of flexible spending arrangements.

A similar rule excludes employer-provided health insurance coverage and reimbursements for medical expenses for employees, their spouses, and their dependents from the employees' wages for payroll tax purposes.[170] The same definition of dependent applies for purposes of this exclusion.

Deduction for health insurance premiums of self-employed individuals

Under present law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents. The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's self-employment income. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than two percent shareholder-employee of an S corporation is treated the same as a self-employed individual. Thus, the exclusion for employer-provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

Voluntary employees' beneficiary associations

A voluntary employees' beneficiary association ("VEBA") is a tax-exempt entity that is a part of a plan for providing life, sick or accident benefits to its members or their dependents or designated beneficiaries.[171] No part of the net earnings of the association inures (other than through the payment of life, sick, accident or other benefits) to the benefit of any private shareholder or individual. A VEBA may be funded with employer contributions or employee contributions or a combination of employer contributions and employee contributions. The same definition of dependent applies for purposes of receipt of medical benefits through a VEBA.

REASONS FOR CHANGE

The Committee recognizes that an increasing number of employers and self-employed individuals offer or desire to offer health coverage and reimbursements for medical expenses to non-spouse, non-dependent beneficiaries, such as same- and opposite-sex domestic partners and their children. Under current law, the provision of these benefits results in additional Federal income tax for the employee or self-employed individual and additional Federal payroll taxes for the employer and the employee. As a result of these additional costs, employers and self-employed individuals may decline to provide coverage to non-spouse, non-dependent

[170] Secs. 3121(a)(2) and 3306(b)(2).
[171] Secs. 419(e) and 501(c)(9).

beneficiaries or, in cases where such coverage is offered, employees may decline it. Either case results in an increase in the number of individuals and families who are not covered by employer-provided health insurance. The provision will end these tax inequities, thereby encouraging employers and self-employed individuals to expand coverage and increase the number of Americans covered by employer-sponsored health plans.

EXPLANATION OF PROVISION

Exclusion for employer-provided health coverage

The provision amends sections 105 and 106 to extend the general exclusion for employer-provided health coverage to eligible beneficiaries.[172] The parallel provisions for excluding employer-provided health care from payroll taxes are also amended.[173] An eligible beneficiary is defined as any individual who is eligible to receive benefits or coverage under an accident or health plan. The provision does not place a limit on the number of eligible beneficiaries an individual is able to claim for purposes of the exclusion.

The provision directs the Secretary of the Treasury to issue guidance providing that eligibility for reimbursements from FSAs and HRAs is extended to otherwise qualifying medical expenses of any eligible beneficiary.

A parallel change is made for VEBAs.

Deduction for health insurance premiums of self-employed individuals

The provision amends section 162(l) to permit self-employed individuals to take a deduction for an individual who meets the following criteria: (1) younger than age 19 (24 for full-time students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) receives more than one-half of his or her support from the taxpayer for the calendar year in which the taxable year begins. The provision does not place a limit on the number of such individuals that a taxpayer is able to claim for purposes of the deduction.

The provision also permits a self-employed individual to take a deduction for an individual who is (1) older than age 19 (or 24 for students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) is not the individual's spouse, qualifying child or qualifying relative. Self-employed individuals may only take a deduction for one such individual in any tax year.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2009.

[172] The provision does not modify the present law dependency exemption.
[173] Secs. 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(24).

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

Part 1—Market Basket Updates

Sec. 1101. Skilled Nursing Facility Payment Update

Current Law

Skilled nursing facilities (SNFs) are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The federal per diem payment is intended to cover all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. The urban and rural federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. This index measures changes in the costs of goods and services purchased by SNFs. Each year, the update of the payment rate also includes, as appropriate, an adjustment to account for the MB forecast error for previous years.

Proposed Law

The provision would eliminate the MB update for FY 2010. For each subsequent fiscal year, the rate would be increased by the skilled nursing facility MB percentage change for the fiscal year involved. This provision would not apply to payments for days before January 1, 2010.

Reason for Change

The Medicare Payment Advisory Commission (MedPAC) makes annual recommendations regarding automatic payment updates in the law for Medicare providers. In MedPAC's assessment, the SNF industry is healthy as the supply of facilities has remained relatively constant over the last four years. The average Medicare margin for free-standing SNFs was 14.5 percent in 2007 and is projected to be 12.6 percent in 2009. Medicare spending on SNFs grew 12 percent from 2006 to 2007, with average annual growth rates of 11 percent from 2000 to 2007. In light of these facts, MedPAC recommended a zero percent update for skilled nursing facilities for FY2010 and the Committee followed this recommendation. The Committee notes that this market basket change is effective for only the last three quarters of FY2010, thus resulting in a small positive update overall. Preliminary estimates are that even with this change, SNFs will yield positive Medicare margins of 7 to 8 percent in FY2010.

The Committee would note that while overall margins may be lower, it is not appropriate to use Medicare Part A Trust Fund dollars to cross-subsidize Medicaid payment rates, which are set at the state level, independently by each state governor.

The Committee would also highlight that skilled nursing facilities directly benefit by the extension of the exceptions process for

therapy services included in this Act and by removing clinical social workers from the SNF consolidated billing requirement.

Effective Date

October 1, 2010.

Sec. 1102. Inpatient Rehabilitation Facility Payment Update

Current Law

Starting January 1, 2002, payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Typically, the per discharge payment amount is increased each fiscal year by an update factor based on the increase in the market basket index. However, for fiscal years 2008 and 2009, the update factor has been set at zero percent, starting for discharges as of April 1, 2008.

Proposed Law

The zero update factor would be extended until September 30, 2010 (the end of fiscal year 2010) but would not apply to payment units occurring before January 1, 2010.

Explanation of Change

MedPAC recommends a zero update for IRFs for FY2010, as indicators of Medicare payment adequacy on net are more positive than negative, capacity remains adequate to meet demand, and MedPAC's assessment is that IRFs can absorb cost increases and continue to provide care to clinically appropriate Medicare cases with no update to payments in 2010. The Committee followed the MedPAC recommendation. The Committee notes that this market basket change is effective for only the last three quarters of FY2010, thus resulting in a small positive update overall.

Effective Date

October 1, 2010.

Sec. 1103. Incorporating Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements

Current Law

Currently, most providers in fee-for-service (or traditional) Medicare, including acute care hospitals, skilled nursing facilities (SNFs), long term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and hospice care receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services purchased by the provider. Annual updates to the Medicare physician fee schedule are determined by a separate method that includes the sustainable

growth rate (SGR) formula, which already incorporates adjustments for gains in physician productivity.

Each year, the Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations for the different payment systems. In its view, Medicare's payment systems should encourage efficiency: providers should be able to reduce the quantity of inputs to produce a unit of service while maintaining quality. Accordingly, MedPAC begins its update deliberations with an assumption that all providers can achieve efficiency gains similar to the economy and examines the Bureau of Labor Statistics' estimate of the 10-year moving average rate of past growth in total factor productivity for the economy as a whole. This policy target links Medicare's expectations for efficiency improvements to the productivity gains achieved by firms and workers who pay taxes that fund Medicare. MedPAC's annual update recommendation will depend on its overall assessment of the circumstances of a given set of providers in any year. These MedPAC recommendations are not binding on Medicare payment policies.

Starting in FY2007, acute care hospitals paid under Medicare's inpatient prospective payment system (IPPS) that do not submit required quality data will have the applicable MB percentage reduced by two percentage points. The reduction would apply for that year and would not be taken into account in subsequent years. Beginning in FY2015, one quarter of the applicable MB update will be reduced if the required quality data are not submitted. Unless significant hardship is demonstrated, the remainder of the MB update (or three-quarters of the MB update) is subject to reduction in IPPS hospitals that are not meaningful electronic health record (EHR) users by FY2015. This reduction will be increased over a three year period. In FY2015, three-quarters of the applicable MB update will be reduced by 31.33%; in FY2016 three-quarters of the applicable MB update will be reduced by 66.66% and in FY2017 and beyond it will be reduced by 100%. These reductions would apply only to the fiscal year involved and would not be taken into account in subsequent fiscal years.

Proposed Law

The update factors for certain providers would include a productivity adjustment. The productivity offset would equal the percentage change in 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity. The estimate used would be that published before the promulgation of the regulation establishing increases in the Medicare rates for the year or period. The productivity adjustment would be included in annual updates for IPPS hospitals, SNFs, IRFs, and hospice care for fiscal years beginning in 2010. To the extent that the base rate for LTCHs would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for rate year 2010. To the extent that the base rate for IPFs would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for rate year 2011.

The percentage of the IPPS update that is reduced by 2 percentage points when the acute care hospital does not submit quality data would not be reduced below zero.

For IPPS hospitals, starting in FY2015, the productivity adjustment would not apply to 75% of the otherwise applicable MB update that is subject to reduction if the hospital is not a meaningful EHR user. In no case would an IPPS hospital receive an annual update for this component of the update that was less than zero.

Reason for Change

The annual update to the Medicare physician fee schedule already incorporates adjustments for gains in productivity. This provision creates uniformity across Medicare providers by creating a productivity adjustment for all Part A providers. This adjustment will encourage greater efficiency in health care provision, hold Medicare providers accountable for achieving productivity gains on par with the overall economy, and more accurately align Medicare payments with provider costs.

Effective Date

October 1, 2010.

Part 2—Other Medicare Part A Provisions

Sec. 1111. Payments to Skilled Nursing Facilities

Current Law

Skilled nursing facilities (SNFs) are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The federal per diem payment is intended to cover all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs.

The "federal per diem rate" is adjusted for treatment type and care needs of the beneficiary based on the resource utilization group (RUG) assignment of the beneficiary. The beneficiary is classified into one of 53 RUG categories. Each RUG represents a payment adjusted for case mix and is composed of three parts. For RUGs used to pay for the care of patients who require intensive therapy, the three parts include (a) a nursing component; (b) a variable therapy component; and (c) a non-case mix adjusted flat rate component. For RUGs used to pay for the care of patients who do not require intensive therapy, the three components are: (a) a nursing component; (b) a flat therapy component; and (c) a non-case mix adjusted flat rate component. The nursing component also includes payment for non-therapy ancillary (NTA) services.

On October 1, 2005, refinements to the SNF PPS became effective. As reported in the SNF FY2009 Proposed Rule, these refinements updated and recalibrated (using FY 2001 claims data) the therapy and nursing case-mix indices associated with all of the RUGs and added nine new Rehabilitation plus Extensive Services groups into the RUG classification system (increasing the number of RUGs from 44 to 53). At the time, the Centers for Medicare and Medicaid Services (CMS) applied a parity adjustment to ensure that estimated total payments under the 53-group model would maintain parity to those that would have been made under the 44-group model in a budget neutral manner. CMS also applied an adjustment to account for the variability in the use of NTA services. After noting that actual utilization patterns differed from what

CMS projected, CMS used actual claims data to update its calibrations and its parity adjustment so as to reestablish budget neutrality (using CY 2006 payment data) and its NTA adjustment component. According to CMS, the total impact of this change for FY 2009, accounting for the market basket increase of 3.1 percentage points, would have resulted in a decrease of 0.3%, assuming facilities do not change their care delivery and billing practices in response. However, this change was never implemented in the final regulation.

The proposed PPS and Consolidated Billing SNF payment regulation for FY 2010 describes how the Secretary would recalibrate the case-mix indexes (CMIs) for 2010 to more accurately match the service needs of beneficiaries, resulting in a $390 million, or 1.2 percent payment reduction from FY2009.

Proposed Law

The proposal would require the Secretary to conduct, using FY2006 claims data, an initial analysis comparing total Medicare SNF payments under the RUG–53 and RUG–44 classification systems. Based on this initial analysis, the Secretary would be required to adjust the case mix indexes for FY2010 by the appropriate recalibration factor, as proposed in the SNF proposed rule issued by the Secretary on May 12, 2009.

In general, the Secretary would be required to increase payments by 10% for non-therapy ancillary services and would be required to decrease payments for the therapy case mix component of such rates by 5.5%. Such payment changes would be required to apply for days on or after January 1, 2010, and until the Secretary implements an alternative case mix classification system for the SNF PPS.

The Secretary would be required to analyze payments for non-therapy ancillary (NTA) services under a future SNF classification system to ensure the accuracy of payments for NTA services. Such analysis would be required to consider use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay diagnoses, broad RUG category, and a proxy for length of stay. Such analysis would be required to be conducted such that the future SNF classification system would apply to services furnished during a fiscal year beginning with FY 2011.

In conducting the analysis, the Secretary would be required to consult with interested parties, including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of NTA costs.

The Secretary would be required to include the result of this analysis in the fiscal year 2011 rulemaking cycle for purposes of implementation beginning for such fiscal year.

The Secretary would also be required to implement changes to payments for NTA services (which would be required to include a separate rate component for NTA services and may include use of a model that predicts payment amounts applicable for NTA services) under such future SNF services classification system as the Secretary determines appropriate based on this analysis. These changes would be required to be implemented such that the estimated expenditures for a fiscal year, beginning with fiscal year

2011, with such changes, would be equal to the estimated expenditures that would otherwise occur under Medicare under such future SNF services classification system for such year without such changes.

With respect to SNF PPS outlier payments for unusual variations in the type or amount of medically necessary care, the Secretary, beginning with October 1, 2010, would be required to provide for an addition or adjustment to the payment amount with respect to NTA services; and may provide for an addition or adjustment to the payment amount otherwise made with respect to therapy services in the case of outliers.

Outlier adjustments or additional payments would be based on aggregate costs during a SNF stay and not on the number of days in such stays. The Secretary would be required to reduce estimated payments that would otherwise be made under the PPS with respect to a fiscal year by 2 percent. The total amount of additional payments or payment adjustments for these outliers with respect to a fiscal year could not exceed 2 percent of total payments projected or estimated based on the SNF PPS.

No administrative or judicial review would be permitted to be conducted regarding these payment changes for NTA or outliers.

Reason for Change

The Committee believes that multiple reforms to the SNF PPS are necessary to improve patient access and quality of care, and ensure payment accuracy and fiscal sustainability in the Medicare program.

In moving from the RUG–44 to the RUG–53 classification system for SNF payments in FY2006, CMS overestimated the adjustment that would be necessary to remain budget neutral—as intended—between these classification systems. This section requires the Secretary to prospectively adjust the payments to account for this error. The Committee notes that the provision does not recollect the overpayments made to SNFs in the past three years. The Secretary proposed this change via regulation in FY2009, but the change was not included in the final regulation for FY2009. In the proposed regulation for FY2010, CMS again proposed to make the adjustment, stating that ". . . the 2006 adjustment inadvertently triggered a significant increase in overall payment levels, representing substantial overpayments to SNFs". According to CMS's analysis, the adjustment necessary to achieve budget neutrality was 9.68 percent, much lower than the actual adjustment provided of 17.9 percent. The Committee intends that moving forward, payments to SNFs should be restored to the appropriate levels by accounting for this error.

MedPAC, CMS and the GAO have identified that the SNF PPS does not accurately account for variability in costs for NTA services, such as intravenous medication or ventilator support. Currently, the SNF PPS pays for NTA services through the nursing component of the PPS, yet NTA costs vary more dramatically than costs for nursing care across stays. For instance, while NTA costs may vary 18-fold for costs per day, the nursing component of the payment only varies by 2-fold. This results in overpayments for beneficiaries who do not need NTA services, and underpayment for those beneficiaries who need expensive NTA services.

Hospitals have reported difficulty placing patients expected to need expensive NTA services in SNFs because facilities expect to be underpaid. While CMS made adjustments for 2006 to account for this payment inaccuracy, including an across-the-board increase to the nursing component, MedPAC advises that the payment is still poorly targeted to accurately pay for NTA services. The current PPS explains 5 percent of the variation in NTA services; a revised system would explain 23 percent of the variance. In order to improve payment accuracy and improve beneficiary access to NTA services, the Committee is providing this short-term adjustment directing the Secretary to conduct an analysis of NTA payments in order to incorporate accurate payments into a future SNF classification system which shall be implemented by FY2011.

At the same time, the current SNF PPS payments for therapy services encourages increased utilization of these services. The share of days grouped into the categories with intensive therapy services has increased from 32 percent in 2001 to 60 percent in 2007. MedPAC reports that some publicly traded nursing homes have increased their focus on patients that need these types of services in order to increase Medicare revenues. The underpayments for patients who need NTA services and the financial incentive to provide therapy services cause a wide divergence in Medicare margins for different facilities, depending on their mix of patients. For instance, for-profit SNFs have Medicare margins of 17.5 percent, while non-profit SNFs have an average Medicare margin of only 4.5 percent. This section would begin to remedy this discrepancy by increasing and better targeting payments for NTA services, and decreasing payments for therapy services.

The Committee is also following MedPAC recommendations by creating an outlier adjustment for NTA services. Medicare has outlier policies for most of its prospective payment systems except SNFs. An outlier policy would increase the accuracy of payments for stays that are exceptionally costly; MedPAC projects that outlier payments would be made for fewer than 2 percent of stays, only after the loss attributable to ancillary services exceeds $3,000. By minimizing financial risks for SNFs, the outlier policy will ensure that potentially high-cost beneficiaries do not experience barriers to access and that costly beneficiaries admitted to the SNF are not denied necessary care. The Committee also notes that reforming the SNF PPS to better capture differences in use of NTA services and adopting an outlier policy would improve the financial situation for hospital-based SNFs.

Effective Date

Subsection (a), pertaining to the recalibration factor, is effective for October 1, 2010. Subsection (b)(1), pertaining to the payment for NTA and therapy services, is effective January 1, 2010. Subsections (b)(2) and (c) are effective for October 1, 2011.

Sec. 1112. Medicare DSH Report

Current Law

Since 1986, an increasing number of acute care hospitals have received additional Medicare payments because they serve a disproportionate share of low-income patients. The original legislative

intent of the DSH adjustment was to compensate hospitals for the higher Medicare costs associated with treating a large proportion of low-income patients. The adjustment is now also considered as a way to protect access to care for vulnerable populations. Most DSH hospitals receive the additional payments based on a formula calculated using the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who receive Supplemental Security Income or SSI) added to the proportion of total hospital days provided to Medicaid recipients. A few urban hospitals receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from State and local indigent care funds.

Proposed Law

No later than July 1, 2016, the Secretary would be required to submit a report on Medicare DSH that would take into account the impact of health reform in reducing the number of uninsured individuals. The report would include recommendations concerning the appropriate amount, targeting, and distribution of Medicare DSH payments to compensate hospitals for their higher Medicare costs associated with serving low-income beneficiaries, consistent with the original intent of Medicare DSH adjustment, taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size. The report would also address the appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent that such costs remain. The Secretary would coordinate the issuance of this report with this legislation's required report on Medicaid DSH.

If there is a significant decrease in the national rate of uninsurance as a result of this legislation, starting in FY2017, the Secretary would implement a Medicare DSH adjustment based on the recommendations of the required report that would take into account variation in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size. An additional hospital payment would be made based on the estimated amount of uncompensated care, excluding bad debt, provided by the hospital.

A significant decrease in the national rate of uninsurance would be established if there is a decrease in the uninsured under-65 population from 2012 to 2014 that exceeds eight percentage points. This rate for a year would be determined by the Bureau of Census in its Current Population Survey that is published in or about September of the succeeding year.

For each fiscal year (starting in FY2017) the Secretary would estimate the aggregate reduction in the amount of the Medicare DSH payments by implementing the empirically justified DSH adjustment. The Secretary would compute the additional hospital payments for uncompensated care so that the estimated aggregate amounts for the fiscal year do not exceed 50% of the aggregate DSH reduction. Also, hospitals with higher levels of uncompensated care would receive higher uncompensated care payments.

Reason for Change

The reforms provided under Division A are expected to expand health insurance coverage and lower the number of individuals who lack insurance. To the extent there are fewer uninsured individuals, the need for Medicare DSH may be somewhat lessened. However, the Committee is very concerned that some individuals will still lack access to health insurance, presenting a continued and strong need for Medicare DSH. The committee is reluctant for any Medicare DSH cuts to go into effect until a drop in the uninsured rate occurs.

Furthermore, the Committee notes that the original statutory intent for Medicare DSH still exists, and Medicare must continue to compensate hospitals for the additional costs per Medicare case that are linked to serving low-income patients in a hospital. According to analysis in its June 2007 report, MedPAC found a stronger and much larger relationship between Medicare costs and the share of low-income patients observed at urban hospitals with more than 100 beds. MedPAC found no positive cost relationship between care to the poor and costs per case for rural hospitals and urban hospitals with fewer than 100 beds. It is the Committee's intent that in continuing to compensate for the empirically justified level of Medicare DSH, the Secretary shall set, and vary, the amount in a manner such that differences in hospital size are taken into account.

Effective Date

July 1, 2016.

Sec. 1113. Extension of Hospice Regulation Moratorium

Current Law

The prospective payment methodology for hospice was established in 1983. This prospective payment system (PPS) pays hospices according to the general type of care provided to a beneficiary on a daily basis. This rate attempts to adjust for geographic differences through a wage index adjustment. The current hospice wage index methodology was implemented in 1997 through the rule making process. The hospice wage index is updated annually and based upon the most current hospital wage data and any changes to the Office of Management and Budget's (OMB) Metropolitan Statistical Areas (MSA) definitions. Prior to this date, the wage adjustment used a hospice wage index based upon 1981 hospital data collected by the Bureau of Labor Statistics (BLS). The change in 1997 was intended to improve the data used to account for disparities in geographic location and improve accuracy, reliability, and equity of Medicare payments to hospices across the country.

When the data source used to adjust hospice payments for differences in the cost of labor across geographic area was changed in 1997 from the 1983 Bureau of Labor Statistics data to the hospital wage data, a budget neutrality adjustment factor (BNAF) was instituted by the Secretary to prevent participating hospices from experiencing reductions in total payments as a result of the change. This BNAF increases payments to those hospices that would otherwise experience a payment reduction by boosting hospice payments

to these providers by amounts that would make overall payments budget neutral to the levels that they would have received had the Secretary used the 1983 Bureau of Labor Statistics wage adjustment. According to the proposed rule published by the Department of Health and Human Services (HHS) in the Federal Register on May 1, 2008, the BNAF boosts total payments to hospice providers by about 4%.

According to the Hospice FY 2010 final rule, published in the Federal Register on August 6, 2009, the BNAF was modified to be phased out over 7 years instead of 3 years. The BNAF phase-out would begin with a 10 percent reduction in FY 2010 and an additional 15 percent reduction for each year over the next 6 years.

The BNAF phase-out has been controversial. Many policymakers rejected the prospect of payment reductions for hospice. As a result, the American Recovery and Reinvestment Act of 2009 (P.L. 111–5) included a provision that delayed the implementation of the phase-out of the budget neutrality adjustment factor during FY2009. Consequently, Medicare payments to 145 hospice during FY2009 will contain budget neutrality adjustments similar to those in previous years. Without changes to current law, the phase-out will begin in FY2010, starting on October 2, 2009. Industry groups have also filed a lawsuit to block implementation of the final hospice payment rule.

Proposed Law

The provision would extend the delay on the implementation of the phase-out of the budget neutrality adjustment factor until October 1, 2010.

Reason for Change

Hospice programs served nearly one million Medicare beneficiaries and their families in 2007, providing compassionate end-of-life care. A moratorium on the Medicare regulation for fiscal year 2010 would ensure that hospices continue to receive the same reimbursement rate for wages.

Subtitle B—Provisions Related to Part B

Part 1—Physicians Services

Sec. 1121. Sustainable Growth Rate Reform

Current Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variation in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The law specifies a formula, commonly referred to as the sustainable growth rate (SGR) system, for calculating the annual update to the conversion factors and the resulting fees.

If cumulative physician expenditures are below the expenditure target, then an annual update is increased by at least the Medicare Economic Index (MEI). (Created in 1975, the MEI is an inflation

index similar to the CPI that includes the prices of inputs required for the production of physician services including the physician's time, the cost of hiring employees such as technicians and clerical staff, rent, medical equipment, supplies, and drugs.) However, if cumulative physician expenditures exceed the expenditure target, then the annual update factor for all physician payments under the fee schedule are reduced in an attempt to bring expenditures in line with the target.

Reductions resulting from application of the SGR have been frequently overridden by legislation. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110–173, MMSEA) increased the update to the conversion factor for Medicare physician 146 payment by 0.5% compared with 2007 rates for the first six months of 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) extended the 0.5% increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008 and set the update to the conversion factor to 1.1% for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied, so unless further legislation is passed, the update formula will require a 21% reduction in physician fees beginning January 1, 2010 and by additional amounts annually for at least several years thereafter.

The calculation of the expenditure target has been criticized for including items that are not reimbursed under the Medicare physician fee schedule. Specifically, MedPAC and various physician organizations have suggested removing Part B drugs from the calculation of the baseline and growth targets. In its proposed rule for payment for physicians' services in 2010, CMS proposed removing Part B drugs from those targets.

Proposed Law

The bill would make a number of substantial revisions to the SGR formula. Instead of grouping all physician expenditures together in the calculation of the annual update to the fee schedule, the bill would establish two separate target growth rates, one for evaluation and management services and preventive services and another for all other physician services.

The bill would also rebase the revised formula for the purposes of calculating future expenditure targets. Instead of setting the expenditure target using physician expenditures since April 1, 1996, the proposal would base the new physician expenditure targets on physician expenditures beginning January 1, 2009, with future targets determined under a revised formula. The proposal would also exclude "incident to" services such as prescription drugs from the formula, limiting services included in the target growth rate computation to services paid for under the physician fee schedule.

The bill would modify how updates to the fee schedule would be determined. For 2010, the update to the single conversion factor would be the percentage increase in the MEI. To calculate future updates, separate target growth rates would be established for two categories of services: evaluation and management services and all other services. Evaluation and management services would include procedure codes for Medicare covered services in the category designated Evaluation and Management in the Health Care Common

Procedure Coding and Medicare covered preventive services. The service categories would apply without regard to the specialty of the physician providing the service. The calculation of the update factors would be based on physician expenditures in these categories beginning January 1, 2009.

The application of multiple conversion factors would begin with 2011. The initial conversion factors for 2011 would be based upon the single conversion factor for 2010 multiplied by the update factors for such category for 2011. To update the conversion factors for the two service categories in subsequent years, the conversion factor for each category for the previous year would be adjusted by the update established for the category.

In determining the allowed expenditures for 2010, total 2009 actual expenditures for all services included in the target spending formula computation for each service category would be increased by the growth rate to obtain 2010 allowed expenditures for each service category. In subsequent years, the amount of allowed expenditures for such category would be the allowed expenditures for the preceding year increased by the target growth rate (as described below) for such category and year.

Each category would have a separate target growth rate. The target growth rate for a given year, beginning with 2010, would be computed and applied separately for each service category (as defined above) and would be computed using the same method for computing the target growth rate except that the update to the conversion factor for evaluation and management services as well as Medicare covered preventive services would be allowed to increase by the percentage growth rate of Gross Domestic Product (GDP) per capita plus two percentage points, while the increase for all other physicians' services would be allowed to grow at the percentage rate of increase in GDP per capita plus one percentage point. The Secretary would publish the target growth rate for such succeeding year and each of the two preceding years by November 1 of each year.

Providers participating in the accountable care organization (ACO) pilot program would have the option of pursuing separate target growth amounts applicable only that organization. No later than January 1, 2012, the Secretary would develop a method that would (1) allow each ACO to have its own Medicare physician fee schedule expenditure targets and updates that would be consistent with the methodologies described above, and (2) provide that the target growth rate applicable to other physicians would not apply to physicians to the extent that their services are furnished through the ACO. This method would apply beginning with 2012. In determining the expenditure targets and updates for physicians in the ACO pilot program, the Secretary could apply the difference in the update on a claim-by-claim or lump sum basis and such a payment would be taken into account under the pilot program.

Reason for Change

Despite recommendations from MedPAC and others overhaul the SGR mechanism, Congress has consistently failed to make substantive changes to the formula. Since 2002, Congress has enacted a series of short-term fixes that have avoided payment reductions called for by the SGR, but failed to address the fundamental flaws

with the formula. Meanwhile, the projected budgetary cost of comprehensive reform to the SGR has soared and the depth of required payment rate reductions have deepened.

The Committee has long recognized that the current update methodology is unsustainable and must be replaced. This legislation makes needed reforms that reflect more realistic allowances for growth in spending on physician services, while still holding physicians accountable for overall spending on the services they provide.

Creating two separate expenditure targets and allowing higher growth for evaluation and management and preventive services infuses additional resources into these services to encourage their use. Furthermore, removing labs, drugs, and other "incident to" services from the calculation will result in the targets being more closely aligned with actual spending for physician services, rather than drug price inflation.

When developing the evaluation and management service category, the Secretary should give strong consideration to including codes described as medical examination, evaluation, and management services that do not fall in the traditional grouping of evaluation and management services. For example, certain ophthalmology services are not included in the evaluation and management procedure codes, but encompass a similar array of services described by the evaluation and management codes.

In addition, the Secretary should make appropriate adjustments to the each of the spending targets following any administrative adjustments to relative value units for services under the fee schedule. Such adjustments will avoid confounding actual growth for each spending category with administrative changes how physician services are valued.

Allowing Accountable Care Organizations to have their own unique spending targets will increase the incentive for physicians to form or join such organizations. Physicians who participate in ACOs and choose to have their own spending targets will be held harmless from spending growth on physician services that occurs outside the ACO, further incentivizing those physicians to provide efficient, coordinated care. The Committee believes the connection between these two payment policies has great potential to reduce the rate of spending growth in the Medicare program and result in better care for Medicare beneficiaries.

Effective Date

January 1, 2010.

Sec. 1122. Misvalued Codes Under the Physician Fee Schedule

Current Law

The Medicare physician fee schedule is based on assigning relative weights to each of the approximately 7,500 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in 149 providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The Centers for Medicare and Medicaid Services (CMS), which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments. In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased; new technologies that have been introduced into coverage with relatively high RVUs also contribute to this problem. CMS is required to review the RVUs no less than every five years.

In determining adjustments to RVUs used as the basis for calculating Medicare physician reimbursement under the fee schedule, the Secretary has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required publish an explanation of the basis for such adjustments.

These adjustments are subject to a budget neutrality condition. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the Medicare physician fee schedule to differ from year to year by more than $20,000,000 from the expenditures that would have been incurred without such an adjustment.

Under current law, the Secretary appoints 15 physicians (nominated by physicians organizations) to form the Practicing Physicians Advisory Council, including both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas. This council meets each quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary.

Section 4505(d) of the Balanced Budget Act of 1997 (P.L. 105–33, BBA) requires that, in developing the resource based practice expense RVUs, the Secretary (1) use generally accepted cost accounting principles, to the maximum extent possible, that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization, (2) develop a refinement method to be used during the transition, and (3) consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician practice expense.

Proposed Law

The Secretary would periodically identify and make appropriate adjustments to the relative values for the services identified as being potentially misvalued. The Secretary would examine the following, as appropriate: (1) codes (and families of codes as appropriate) for which there has been the fastest growth; (2) codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; (3) codes for new technologies or services within an appropriate period (such as three years) after

the relative values are initially established for such codes; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and (7) such other codes determined to be appropriate by the Secretary.

In conducting the review and adjustments, (1) the Secretary could use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services; (2) the Secretary could conduct surveys, other data collection activities, studies, or other analyses as appropriate to facilitate the review and appropriate adjustment; (3) the Secretary could use analytic contractors to identify and analyze potentially misvalued services identified, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services; (4) the Secretary could coordinate the review and appropriate adjustment with the existing periodic (no less often than every 5 years) review of the relative values; (5) the Secretary could make appropriate coding revisions (including using existing processes for consideration of coding changes) that could include consolidation of individual services into bundled codes for payment under the fee schedule; and (6) the Secretary would apply the existing budget neutrality condition that applies to relative value adjustments to this proposal.

The Secretary would establish a process to validate relative value units under the fee schedule. The evaluation process could include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and could include validation of the pre, post, and intra-service components of work. The validation of work relative value units would include a sampling of codes for services that is the same as the potentially misvalued codes described above.

The Secretary could conduct the validation using methods described above to identify potentially misvalued services, as the Secretary determines to be appropriate. Following the evaluation, the Secretary would make appropriate adjustments to the work relative value units under the fee schedule. The same budget neutrality provision would apply to adjustments to relative value units made as a result of the evaluation.

For FY2010 and each subsequent fiscal year, $20 million would be appropriated for the CMS Program Management Account to carry out the provisions described above. The amounts appropriated for a fiscal year would be available until expended.

The provision also clarifies how certain existing statutes might pertain to the proposals contained in this section. Chapter 35 of title 44 of the United States Code, pertaining to the Coordination of Federal Information Policy, and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) would not apply to the modifications proposed in this section. Notwithstanding any other provision of law, the Secretary could implement the proposed modifications in order to identify, adjust, and evaluate potentially misvalued codes by program instruction or otherwise. Section 4505(d) of BBA, which placed requirements on how the Secretary

developed the practice expense RVUs, would be repealed. Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation would not apply to this section or the amendment made by this section. Finally, the statute establishing the Practicing Physicians Advisory Council would be repealed.

Reason for Change

Traditionally the five-year review has led to more increases in work RVUs than decreases. MedPAC and other observers have stated that more attention needs to be given to the accurate valuation of services in order to maintain the integrity of the fee schedule.

The provision gives clearer direction to the Secretary to maintain accurate valuation of services and prioritizes identification of potentially misvalued codes. For instance, rapid rises in the volume of administratively priced services can be a warning sign of incorrect incentives; this problem can be addressed by giving the Secretary authority to impose a downward adjustment in the price of rapidly rising services (after taking into account evidence of clinical benefit that would justify growth) to be reconsidered by outside consultants during the five year review. The provision also addresses concerns that CMS does not have sufficient resources or administrative authority to conduct such reviews; among other improvements, providing additional resources will promote collection of more timely and accurate data that can be used to improve valuation of services.

Effective Date

Date of enactment.

Sec. 1123. Payments for Efficient Areas

Current Law

Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas.

Proposed Law

The proposal would create new incentive payments for "efficient" areas. Providers delivering services on or after January 1, 2011, and before January 1, 2013 who practice in an area identified as an "efficient" area would receive an additional payment (on a monthly or quarterly basis) equal to 5% of the payment amount for the Medicare Part B services.

Based upon available data, the Secretary would identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for Medicare Part A and part B services provided in the most recent year for which data are available as of the date of the enactment. The Sec-

retary would standardize per capita spending to eliminate the effect of geographic adjustments in payment rates.

For purposes of the additional payment for providers in "efficient" areas, if the Secretary were to use the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code would be used to determine whether the postal ZIP Code is in a county described as an "efficient" area. There would be no administrative or judicial review respecting (1) the identification of a county or other area as an efficient area; or (2) the assignment of a postal ZIP Code to a county or other area designated as an efficient area.

The Secretary would identify counties or areas designated as "efficient" as part of the proposed and final rule to implement the physician fee schedule for the applicable year. The Secretary would post the list of counties identified as "efficient" on the CMS website.

Reason for Change

In certain regions of the country, Medicare beneficiaries use a very low volume of services. This could be caused by problems with access to physician services or highly efficient practice by local physicians. The incentive payments would either address problems with access or reward efficient practice.

Effective Date

January 1, 2011.

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI)

Current Law

Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109–432) required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. CMS named this program the Physician Quality Reporting Initiative (PQRI). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010.

Providers that successfully report for services provided in calendar year 2009 will receive an incentive payment of two percent of total allowable charges for the physician fee schedule. Providers may choose claims-based reporting or registry-based reporting. For claims-based reporting, providers seeking incentive payments for the entire calendar year may meet the requirement by reporting on one measures group for a sample of 30 consecutive Medicare Part B fee-for-service patients (FFS), or report for one measures group for 80% of applicable Medicare Part B FFS patients. For providers seeking to report for the six-month period beginning July 1, 2009, similar criteria apply for those that report through CMS approved registries.

Proposed Law

The bill would modify the PQRI to include a feedback program for physicians, integrate PQRI and electronic health record (EHR) reporting, and extend the years of bonus payments. Not later than January 1, 2011, the Secretary would develop and implement a mechanism to provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under the PQRI program.

Not later than January 1, 2011, the Secretary would establish and have in place an informal process for eligible professionals to appeal the determination that an eligible professional did not satisfactorily submit data on quality measures for the PQRI program.

The bill would integrate physician quality reporting under the PQRI and EHR reporting relating to the meaningful use of EHR. The integration would consist of the following: (1) the development of measures that would both demonstrate meaningful use of an electronic health record for purposes of EHR reporting and provide information on the clinical quality of the care furnished to an individual; (2) the collection of health data to identify deficiencies in the quality and coordination of care for Medicare beneficiaries; and (3) other activities as specified by the Secretary. The Secretary would develop such a plan no later than January 1, 2012.

Incentive payments under the PQRI program would be extended through 2012; for each of the years 2009 through 2012, the bonus would be 2% of Part B payments.

Reason for Change

The PQRI program has the potential to be a valuable tool in measuring the quality of services furnished by physicians to Medicare beneficiaries. However, its potential usefulness has been undermined by problems with the way the initiative has been implemented. This section addresses those problems, extends the payment initiative for several years, and improves the program by integrating it with the incentive program for the adoption and use of health information technology.

Effective Date

Date of enactment.

Sec. 1125. Adjustment to Medicare Payment Localities

Current Law

The Medicare fee schedule pays providers differently according to the geographic location, known as a Medicare physician payment locality, in which the provider practices. At the time when they were originally defined the costs of providing physician services were relatively consistent within each payment locality; sub-regions of a state were designated as separate payment localities only if the data showed a marked difference between the costs in that area compared with the rest of the state.

Each year, the Centers for Medicare and Medicaid Services (CMS) uses data from a number of sources to calculate separate geographic practice cost indices (GPCIs) for each payment locality for each of three component inputs required to produce physician serv-

ices (physician work, practice expense, and medical malpractice insurance). For each locality, these 3 GPCIs are then combined to produce a weighted average index of relative costs, called the geographic adjustment factor (GAF).

In constructing the payment localities, the Health Care Financing Administration (HCFA, now CMS) used an iterative criteria that compared the relative cost (the GAF) of a potentially distinct locality with the weighted average costs (GAFs) in the rest of the state. Localities that had GAFs at least 5% higher than the rest of the state were designated as a separate locality; this process was repeated until this condition was not met, whereupon the remaining regions of the state were combined into one locality. In 1996, HCFA reduced the number of Medicare localities for physician payment by aggregating several existing contiguous localities with similar costs and combining other localities to create a single payment area for the entire state. As a result, there are currently 89 Medicare physician payment localities based on counties or aggregates of counties across the 50 states; some localities are the entirety of the state while other states may have several payment localities. None of the payment localities cross state lines.

Economic conditions have affected parts of the country differently in the years since the payment localities were created. If localities were to be created based on data from recent years using the original methodology, the resulting number and composition of the payment localities might not be the same as the ones that currently exist.

Proposed Law

The payment localities used as the basis for the geographic adjustment of Medicare physician payments under the fee schedule would be changed in the state of California. Under the proposal, payments to California physicians would transition from a system based on the current localities to one based on Metropolitan Statistical Areas (MSAs). For services furnished on or after January 1, 2011, the Secretary would revise the Medicare physician payment areas for the State of California to be based on Metropolitan Statistical Areas (MSA).

The methodology for constructing the new payment areas would be similar to the original methodology, but the Core-Based Statistical Areas-Metropolitan Statistical Areas, as defined by the Office of Management and Budget (OMB), would be used as the geographic units for comparing GAFs. First, the Secretary would list all MSAs within California by their GAFs in descending order. In the first iteration, the Secretary would compare the GAF of the highest cost MSA in the State to the weighted-average GAF of the group of remaining MSAs in the State. If the ratio of the GAF of the highest cost MSA to the weighted-average GAF of the rest of State is 1.05 or greater than the highest cost MSA becomes a separate fee schedule area. In each subsequent iteration, the Secretary would compare the MSA of the next-highest GAF to the weighted-average GAF of the group of remaining MSAs. If the ratio of the next-highest MSA's GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, that MSA would become a separate fee schedule area. The iterative process would continue until the ratio of the GAF of the highest-cost remaining MSA to the

weighted-average of the remaining lower-cost MSAs is less than 1.05, and the remaining group of lower cost MSAs would form a single fee schedule area. If two MSAs were to have identical GAFs, they would be combined in that step of the iterative comparison.

The provision would require that no GPCIs be reduced during the first 5 years of the transition from the former county-based payment localities to the MSA-based fee schedule areas. For services furnished in California on or after January 1, 2011 and before January 1, 2016, the Secretary would increase any such index to the county-based fee schedule area value on December 31, 2009, if the index under the new calculation would be less than the value on January 1, 2010.

The new fee schedule areas would be subject to periodic review and adjustments. Not less often than every 3 years, the Secretary would review and update the California Rest-of-State fee schedule area using MSAs as defined by the OMB applying the iterative methodology described above. This revision would be made effective concurrently with the application of the periodic review of the adjustment factors required under current law for California for 2012 and subsequent periods and would be linked to the review of the GPCIs for all fee schedule areas that occurs not less often than every 3 years. Upon request, the Secretary would make any county-level or MSA-derived data used to calculate the geographic practice cost index available to the public.

Reason for Change

A GAO report issued July 2007 confirmed significant problems with inaccurate pricing that result from current methodology used to establish Medicare's payment localities. While the problem is not limited to California, during the last 15 years that state has experienced some of the largest economic and demographic shifts, leading to large disparities between local costs and geographic price adjustments. Revising and updating the state's payment localities to reflect costs at the MSA level will achieve the greatest balance between price accuracy and administrative feasibility. In order to minimize the effect of resources shifting from one area of the state to another that result from this change, the legislation provides temporary relief to counties in California that would be adjusted downward.

Effective Date

January 1, 2010.

Part 2—Market Basket Updates

Sec. 1131. Incorporating Productivity Improvements into Market Basket Updates That Do Not Already Incorporate Such Improvements

Current Law

Medicare pays for hospital outpatient department services under its outpatient prospective payment system (OPPS). Generally, Medicare's OPPS base payment amount is increased each year by an annual update that is linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services purchased by the pro-

vider. Starting in CY2009, hospitals paid under OPPS that do not submit required quality data will have the applicable MB percentage reduced by two percentage points. The reduction would apply for that year and would not be taken into account in subsequent years.

Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. The national fee schedule is fully phased-in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007–2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount. The fee schedule amounts are updated each year by the consumer price index for all urban consumers (CPI-U).

Starting January 1, 2008, Medicare will pay for surgery-related facility services provided in an ambulatory surgery center (ASC) using a payment system based on the hospital OPPS. The new payment system will be implemented over a four-year transition period. Beginning in CY2010, the ASC conversion factor will be updated annually using the CPI-U. This update will be subject to a 2 percentage point reduction if required quality data are not provided.

Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are periodically updated. The annual clinical laboratory test fee schedule update adjustment for 2009–2013 will be the percentage increase or decrease in the CPI-U minus 0.5 percentage points.

Except in Competitive Acquisition Areas where payments for items and services are to be based on suppliers' bids, Medicare pays for durable medical equipment (DME) on the basis of fee schedules. Items are classified into five groups for determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which are purchased at least 75% of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. In general, fee schedule amounts are updated annually by the CPI-U. Updates were eliminated for 1998–2000; payments were increased by the CPI-U for 2001; and payments were frozen for 2002. MMA eliminated the updates for 2004–2008. In 2009, for items and services selected before July 1, 2008 to be part of a Competitive Acquisition Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), the update was a decrease of 9.5 percent. This decrease applied across geographic areas and was not restricted to Competitive Acquisition Areas. This adjustment allowed provisions in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L.110–275) delaying the implementation of the Competitive Acquisition Program to be budget neutral. For items and services that had not been selected before July 1, 2008 to be part of the Competitive Acquisition Program, the payment update for 2009 was the CPI-U. For 2010 through 2013, the updates are to be the CPI-U. In 2014, if an item received a payment decrease

in 2009, the update is to be equal to the CPI-U plus 2 percentage points, otherwise the update is to be the CPI-U. Starting in 2015, the update is to be the CPI-U. Payment updates for DME do not include an adjustment for productivity.

Proposed Law

Starting in CY2010, the OPPS, ambulance services, clinical laboratory services updates would be subject to the productivity adjustment established earlier in the legislation and applicable to certain Part A providers, including IPPS hospitals. Starting in CY2010, to the extent an annual percentage change factor applies to ASC services, it would include the productivity factor established earlier in legislation.

Reason for Change

The annual update to the Medicare physician fee schedule already incorporates adjustments for gains in productivity. This provision creates uniformity across Medicare providers by creating a productivity adjustment for other Part B providers. This adjustment will encourage greater efficiency in health care provision, hold Medicare providers accountable for achieving productivity gains on par with the overall economy, and more accurately align Medicare payments with provider costs.

Effective Date

January 1, 2010.

Part 3—Other Provisions

Sec. 1141. Rental and Purchase of Power-driven Wheelchairs

Current Law

Wheelchairs, including power-driven wheelchairs, are covered by Medicare Part B under the capped-rental category of the durable medical equipment (DME) benefit. Medicare pays for power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months), or payment is made on a lump-sum basis at the time the supplier furnishes the chair, if the beneficiary chooses the lump-sum payment option. The same payment choice applies to replacement power-driven wheelchairs as well.

Medicare covers over 600 power wheelchair models under 42 procedure codes (Healthcare Common Procedure Coding System, HCPCS). Power wheelchairs are further classified into 3 broad groups based on their reported performance in categories such as speed, range of travel and the height of the vertical obstruction they can climb. Group 3 must meet the highest performance standards. Group 2 and Group 1 must meet intermediate and the lowest performance requirements, respectively. For example, a group 3 wheelchair must be able to travel a minimum of 12 miles on a single charge of its batteries, while the minimum travel requirements for Group 2 and Group 1 chairs are 7 and 5 miles, respectively.

The Secretary is required to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program would replace the Medicare fee schedule pay-

ments. The program is to be phased in, starting in 10 of the largest metropolitan statistical areas (MSAs) in 2009; expanding to 80 of the largest MSAs in 2011 and remaining areas after 2011. The Secretary is permitted to phase in first items and services with the highest cost and highest volume, or those items and services that the Secretary determines to have the largest savings potential first, which includes power-driven wheelchairs.

Proposed Law

This provision would restrict the 'lump-sum' payment provision for new and replacement power-driven wheelchairs to those recognized by the Secretary as classified within group 3 or higher. The provision would be effective for chairs furnished on or after January 1, 2010, but would not apply to competitive bidding areas where bids had been submitted before October 1, 2010.

Reason for Change

By eliminating the first month full purchase option, the provision reduces waste in the Medicare program as there are a sizeable number of wheelchairs which are purchased in the first month, but end up not needed by the beneficiary beyond the 13-month window during which rental payments would otherwise be made. Furthermore, this change protects beneficiaries from the burden of paying the cost-sharing associated with the wheelchair in one lump sum, as would be the case under a first-month purchase.

The Committee is concerned about the practical requirements of this provision for patients whose complex medical conditions justify the outright purchase of mobility devices rather than short- or long-term rentals. These special needs patients will require wheelchairs that are highly customized, use complex technologies, and are in use for very long periods—if not for the rest of the patient's life. As such, the provision continues to allow for first-month purchase of complex mobility devices classified as group 3 or higher.

Effective Date

January 1, 2011.

Sec. 1142. Extension of Payment Rule for Brachytherapy

Current Law

The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L. 108–173) required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. As mandated by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109–432), this separate payment will be made using hospitals' charges adjusted to their costs until January 1, 2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110–173) extended cost reimbursement for brachytherapy services until July 1, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) extended cost reimbursement for brachytherapy until January 1, 2010.

Proposed Law

The provision would extend cost reimbursement for brachytherapy until January 1, 2012.

Reason for Change

This section guarantees access to care for beneficiaries who need brachytherapy.

Effective Date

Date of enactment.

Sec. 1143. Home Infusion Therapy Report to Congress

Current Law

Infusion therapy involves the administration of medication through a needle or a catheter. If a physician determines that it is medically appropriate for a particular patient, some infusion therapies may be provided in a patient's home. Infusion therapies that can be provided in the home include such things as antibiotic therapy, chemotherapy, pain management, and hydration therapy.

Infusion drugs administered in a patient's home are covered under the Medicare Part D drug benefit. Medicare Part D does not, however, cover supplies, equipment or professional services associated with home infusion therapy.

Proposed Law

The provision would require the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress not later than 12 months after the date of enactment. The report would be required to include (a) an analysis of the scope of coverage for home infusion therapy services (and the scope of services provided) in traditional Medicare, Medicare Advantage, the Veterans Health Administration, and among private payers; (b) the benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital or nursing home stays; (c) an assessment of data on home infusion therapy that might be used to construct payment mechanisms under Medicare; and (d) recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy services, including an analysis of MA and private plan payment methodologies for home infusion therapy and their applicability to the Medicare program.

Reason for Change

The Committee is concerned about beneficiary access to home infusion therapy services under Medicare. While Part D pays for the infusion therapy medications, it does not cover the associated supplies or services to administer the medications. The Secretary has directed Part D plans to ensure that beneficiaries have access to an entity—such as a home health agency or outpatient facility—where these supplies and services are available before dispensing home infusion drugs. But receiving infusion drugs through a home health agency or outpatient facility may not be optimal for many beneficiaries. This study would assist the Committee in under-

standing the most appropriate course of action to ensure that beneficiaries have proper access to home infusion therapy services.

Effective Date

Date of enactment.

Sec. 1144. Require Ambulatory Surgical Centers (ASCs) to Submit Cost Data and Other Data

Current Law

Ambulatory surgery centers (ASCs) must meet certain health, safety, and other specified standards in order to participate in Medicare. The Centers for Medicare and Medicaid Services is implementing a new payment system for ASCs starting in January 1, 2008. The new payment system, which will be phased in over a 4-year period, uses the ambulatory payment classification groups that are the basis for Medicare's outpatient prospective payment system (OPPS) for hospital outpatient departments. ASCs have never been required to submit cost reports. In March 2009, the Medicare Payment Advisory Commission recommended that Congress require ASCs to submit cost data and quality data that would allow for an effective evaluation of the adequacy of Medicare's payment rates.

Proposed Law

The Secretary would require ASCs to submit reports on their facility costs as a condition for agreeing to participate in Medicare. The specifications for this data would take into account the requirements for hospital cost data. No later than 3 years from enactment, an ASC cost reporting form would be developed. The ASC cost reports would be periodically audited. The requirements would apply to agreements applicable to cost reporting periods beginning 18 months after the date the Secretary develops the cost reporting form. The Secretary would require ASCs to report quality data, including data on health care associated infections. The amendment would apply starting 2012.

Reason for Change

The number of Medicare-certified ASCs has increased substantially in recent years, growing at an annual rate of 6.7 percent from 2002 to 2007. Spending per beneficiary also increased substantially during that time period, growing at an average annual rate of 8.4 percent. ASCs received $2.9 billion in payments from Medicare and beneficiary cost-sharing in 2007. Ninety-one percent of ASCs have at least one physician owner and MedPAC has advised that the presence of physician ownership of ASCs may influence referral patterns.

MedPAC uses cost data to analyze the adequacy of Medicare payments in many areas. However, cost data are not available for ASCs, thus limiting MedPAC's ability to assess payment adequacy. This provision requires collection of cost report data, which will allow for proper assessments of Medicare's payment adequacy for ASCs. This provision also follows MedPAC's recommendation to require reporting of quality data.

Effective Date

The requirement to submit cost reports is effective 18 months after the Secretary develops a cost report. The quality reporting requirement is effective January 1, 2012.

Sec. 1145. Treatment of Certain Cancer Hospitals

Current Law

Eleven cancer hospitals are exempt from the inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. Historically, they have been paid on a reasonable cost basis, subject to certain payment limitations and incentives. These hospitals are also held harmless under the outpatient prospective payment system (OPPS) and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APC) groups.

Proposed Law

The Secretary would be required to determine if the costs incurred by cancer hospitals with respect to APCs exceed those costs incurred by other hospitals reimbursed under OPPS. If the costs in cancer hospitals exceed the costs incurred by other hospitals, the Secretary would be required to provide for an appropriate adjustment for cancer hospitals for services furnished starting January 1, 2011.

Reason for Change

The Committee is concerned that the cost of outpatient services at PPS-exempt cancer hospitals is greater than that at other outpatient hospitals and that these higher costs are not currently reflected and adequately reimbursed under the current payment system. This provision directs CMS to assess whether such a cost differential exists, and if so, to remedy it. The Committee notes that this provision is in addition to the existing hold harmless provision under 1833(t)(7)(D)(ii) of the Social Security Act as the hold harmless will continue to apply in the situation where the combination of existing payments and any payment change under this section results in a payment less than the pre-BBA amount.

Effective Date

January 1, 2011.

Sec. 1146. Medicare Improvement Fund

Current Law

Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries. Under current law, $2.29 billion from the fund are available for services furnished during FY2014 and an additional $19.9 billion are available for FY2014 through FY2017.

Proposed Law

The proposal would modify the amount of monies in the fund so that $8 billion would be available for the period beginning with fiscal year 2011 and ending with fiscal year 2019.

Reason for Change

Over the course of several years, money has been set aside in the MIF to fund policies that would improve and modernize the Medicare program. This provision would fulfill this intent by using the MIF to offset important investments in Medicare made by this bill. The remaining $8 billion will be available to fund increases in payment rates implemented under Section 1158, regarding Medicare geographic payment adjustments.

Effective Date

Date of enactment.

Sec. 1147. Payment for Imaging Services

Current Law

Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business. Setting the equipment use factor at a lower—rather than at a higher—rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC is urging CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services.

According to MedPAC and the Government Accountability Office (GAO), there are opportunities to improve the efficiency of the Medicare fee schedule. In 2005, MedPAC recommended reducing certain fees to account for efficiencies and savings from the technical preparation and supplies achieved when multiple imaging services are furnished sequentially on contiguous body parts during the same visit. Starting January 1, 2006, physicians receive the full technical component fee for the highest paid imaging service in a visit, but technical component fees for additional imaging services are reduced by 25%.

The work relative value units in the Medicare physician fee schedule are developed with input from the physician community. Refinements in existing values and the establishment of values for new services are included in the annual fee schedule updates. The refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society

Relative Value Update Committee (RUC), which receives input from many physician specialty societies. Current law requires a review of the relative values every five years.

Section 1834(e)(1)(B) of the SSA defines advanced diagnostic imaging services to include diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography), and other diagnostic imaging services as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

Proposed Law

The utilization rate for calculating the payment for advanced diagnostic imaging equipment as defined under current law would be increased from 50% to 75%. For single session imaging involving continuous body parts, the proposal would reduce the technical component fees for additional imaging services to 50%. These modifications would apply to services furnished on or after January 1, 2011.

Reason for Change

MedPAC and other observers have expressed concerns that sizeable increases in the volume of physician services, particularly for imaging services, need to be addressed. Recent MedPAC analysis found problems with the current calculation of practice expenses for certain imaging services. CMS assumes that the equipment is used half the time the practice is open for business. MedPAC found that most advanced imaging equipment is actually in use close to 90 percent of the time. Low assumptions about equipment use artificially inflate the price Medicare pays for imaging services. MedPAC has recommended increasing the utilization assumption for advanced imaging equipment to more accurately reflect actual utilization rates.

MedPAC has also recommended reducing the technical component for a second image on a contiguous body part. When a second image on an adjacent body part is taken, the clerical time, preparation, and supplies needed for the second image are significantly reduced. In 2006, CMS administratively proposed to reduce payment for the second image by 50 percent, but eventually implemented a smaller 25 percent discount. By increasing the discount to 50 percent, this provision would better reflect costs of performing studies on multiple body parts and bring Medicare payment policy in line with private payers.

Effective Date

January 1, 2011.

Sec. 1148. Durable Medical Equipment Program Improvements

Current Law

The Secretary is prohibited from issuing or renewing a provider number for payment of Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims for a supplier unless the supplier provides the Secretary with a surety bond of not less than 550,000. The Secretary may waive this requirement in the case of a supplier that provides a comparable surety bond

under State law. The final regulation exempts certain individuals from the surety bond requirement, including certain physicians and non-physician practitioners, physical and occupational therapists, state-licensed orthotic and prosthetic personnel, and government-owned suppliers.

Medicare Part B pays for certain items of durable medical equipment (DME) including oxygen and oxygen equipment. The Deficit Reduction Act (DRA, P.L. 109–171) changed how long Medicare would make rental payments for oxygen equipment. It changed from the entire period of medical need, to a rental period of 36 months. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) requires suppliers to continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, which is defined by the Secretary as 5 years (or 60 months).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) required the Secretary to establish and implement quality and accreditation requirements for Medicare suppliers of DMEPOS. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) exempted a group of health care professionals from having to become accredited unless the Secretary determined the standards were designed specifically to be applied to those professionals. The Secretary was given authority to exempt certain professionals from the accreditation requirement if the Secretary determined that licensing, accreditation, or other mandatory quality requirements applied to those professionals. The provision identified some of the professionals subject to the provision, including: physicians; physical or occupational therapists; physicians assistants; nurse practitioners; clinical nurse specialists; orthotists; and prosthetists.

Proposed Law

Surety Bond: This provision would waive the surety bond requirement for a pharmacy that (1) supplies durable medical equipment, prosthetics, orthotics, and supplies, (2) has been issued a provider number for at least 5 years, and (3) has not received an adverse action, as defined in the 'Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges' in the Code of Federal Regulations.

Oxygen Equipment: This provision would modify the time period during which the supplier would be required to furnish medically necessary oxygen and oxygen equipment. As of the 27th month of the 36 month rental period, the supplier furnishing the equipment would be required to continue furnishing the equipment (either directly or through arrangements with other suppliers) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier accepted the responsibility to furnish equipment during the remainder of the period. This provision would be effective upon enactment and would apply to equipment furnished to individuals for whom the 27th month of a continuous period of use occurred on or after July 1, 2010.

This provision would also allow a beneficiary to begin a new 36-month rental period if the supplier who had been furnishing oxy-

gen and oxygen equipment to the beneficiary was declared bankrupt and its assets were liquidated and at the time of the declaration and liquidation more than 24 months of rental payments had been made.

Accreditation: This provision would exempt pharmacies enrolled as Medicare DMEPOS suppliers from the accreditation requirement for the purposes of supplying diabetic testing supplies, canes, and crutches. Any supplier that had submitted an application for accreditation before August 1, 2009 would be deemed as meeting applicable standards and accreditation requirements under the subparagraph until the independent accreditation organization took action on the suppliers application.

Reason for Change

This section will make a number of changes to the durable medical equipment program that will improve the program for beneficiaries. The provisions regarding surety bonds and accreditation recognize the fact that very few pharmacies are involved in fraud associated with the DME program, and the important role pharmacies play in ensuring beneficiaries have access to certain types of medical equipment. Given that income from DME represents a small portion of total revenues for most pharmacies, the Committee is concerned that the cost of complying with the surety bond and accreditation requirements could cause many pharmacies to stop furnishing these items to Medicare beneficiaries.

In addition, this section will make needed changes to the way CMS has implemented the 36 month rental cap on oxygen equipment. Right now, when a beneficiary moves from one area of the country to another after reaching the 36-month rental cap, the supplier is obligated to continue servicing the equipment through the remainder of the useful life of the equiptment. Beneficiaries who move just prior to hitting the 36-month rental cap are not afforded the same protection. Extending the requirement that suppliers continue servicing equipment to earlier in the rental period will protect beneficiaries who move shortly before hitting the 36-month rental cap. This section also provides critical beneficiary protections in instances where an oxygen supplier goes out of business.

Effective Date

Date of enactment.

Sec. 1149. MedPAC Study and Report on Bone Mass Measurement

Current Law

No provision.

Proposed Law

The Medicare Payment Advisory Commission would conduct a study regarding bone mass measurement, including computed tomography, duel-energy x-ray absorptiometry, and vertebral fracture assessment. The study would focus on the following: (1) an assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs; (2) the impact of Medicare payment changes since 2006 on beneficiary ac-

cess to bone mass measurement benefits in general and in rural and minority communities specifically; (3) a review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compares to such recommendations; and (4) in conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries. Not later than 9 months after enactment, the Commission would submit a report to the Congress containing a description of the results of the aforementioned study and the conclusions and recommendations, if any, regarding each of the issues described above.

Reason for change

Dual-energy absorptiometry and vertebral fracture assessment are important in the early detection of osteoporosis and bone fractures. Recent changes in the way that these two tests are valued by Medicare has caused fees to drop and raised questions about whether the program is adequately paying physicians for these services. This policy directs MedPAC to create a study that would evaluate the impact of the Medicare payment changes and will review issues of access in rural and minority communities and the usage rates among Medicare beneficiaries.

Effective Date

Date of enactment.

Subtitle C—Provisions Related to Medicare Parts A and B

Sec. 1151. Reducing Potentially Preventable Hospital Readmissions

Current Law

Medicare pays for most acute care hospital stays using a prospectively determined payment for each discharge. Payment also depends on the relative resource use associated with a patient classification group, referred to as the Medicare Severity diagnosis related groups (MS-DRGs), to which the patient is assigned based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. Medicare's inpatient prospective payment system (IPPS) includes adjustments that reflect certain characteristics of the hospital. For instance, a hospital with an approved resident training program would qualify for an indirect medical education (IME) adjustment; hospitals that serve a sufficient number of poor Medicare or Medicaid patients would receive higher Medicare payments because of their disproportionate share hospital (DSH) adjustment. Hospitals in Maryland are not paid using IPPS; rather they receive Medicare payments based on a state-specific Medicare reimbursement system.

Critical Access Hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds; and have a 96-hour average length of stay. Medicare pays CAHs on the basis of 101% of the reasonable costs of the facility for inpatient and outpatient

services. Certain aspects of the CAH payment system are not subject to administrative or judicial review.

According to Medicare Payment Advisory Commission's (MedPAC) analysis of 2005 Medicare data, 6.2% of hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6% of hospitalizations resulted in readmission within 30 days. The 17.6% of hospital readmission accounts for $15 billion in Medicare spending. These readmission rates reflect the total number of readmissions, including those that may not have been related to the initial diagnosis and may not have been preventable. MedPAC, CMS, and others have expressed concern that providers do not have financial incentives to reduce potentially preventable readmissions. In addition, MedPAC, in its June 2008 report, recommended that Medicare's payments to hospitals with relatively high readmission rates for select conditions be reduced.

Proposed Law

Penalties for Hospitals

IPPS hospitals and those hospitals in Maryland paid under a state-specific Medicare payment system would receive reduced payments for potentially preventable hospital readmissions occurring on or after October 1, 2011. Under this proposal, hospitals with lower potentially preventable readmission rates would receive smaller payment reductions while hospitals with higher potentially preventable readmission rates would receive higher payment reductions. Certain components of Medicare hospital payments would be exempt from these payment reductions.

Reduced hospital payments for readmissions would calculated by multiplying the base operating DRG payment amount by an adjustment amount. The base operating DRG payment amount is the base amount that would have been paid under IPPS, reduced by payments associated with IME and DSH. In the case of hospitals in Maryland, the base amount would be the payment amount under their state system.

The adjustment factor for a hospital in a fiscal year would be the greater of (1) a floor adjustment factor equal to a reduced percentage of the discharge payment or (2) the excess readmissions ratio for the applicable fiscal year. The floor adjustment factor would be 0.99 of the discharge payments in FY2012, 0.98 of the discharge in FY 2013, 0.97 in FY 2014 or 0.95 in subsequent fiscal years. The excess readmissions ratio would equal 1 minus the ratio of the aggregate payments for excess readmissions for the hospital divided by the aggregate payments for all discharges.

Aggregate payments for excess readmissions for a hospital for a fiscal year would be the sum of the applicable conditions of the product of the base operating DRG payment for each applicable condition multiplied by the number of admissions for each condition multiplied by the excess readmissions ratio minus one. The excess readmissions ratio is the ratio of the risk adjusted readmissions based on actual readmissions divided by the risk adjusted expected readmissions. This number would not be less than one. The ratio would be calculated for each applicable condition for a hospital for the applicable period. The aggregate payments for all discharges would be calculated as the sum of the hospital's base oper-

ating DRG payments for all discharges for all conditions for such a fiscal year.

Under the readmissions policy, the Secretary would be prohibited from including conditions for which there are fewer than a certain minimum number (as determined by the Secretary) of discharges within a certain time period. To encourage hospitals to continue to do reduce their potentially preventable readmission rates over time, beginning with discharges for FY2014, the Secretary would be able to determine the excess readmissions ratio based on a ranking of hospitals by readmission ratios (from lower to higher readmissions) normalized to a benchmark that is lower than the 50th percentile.

An applicable condition would be defined as a condition or procedure that represents high volume or high expenditures for Medicare or meets other specified criteria that also satisfies certain measures of readmissions. These measures of readmission would be those that have been endorsed by a consensus based entity with a performance measurement contract under 1890 of the Social Security Act, excluding readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital). Readmission would be defined as an admission to the hospital of an individual who had been discharged from either the same or another applicable hospital within a time period from the date of discharge as specified by the Secretary.

Starting in FY2012, the Secretary would select 3 applicable conditions that have been endorsed by the consensus based entity as of the date of enactment. Beginning with FY2013, the Secretary would be required to expand the list of applicable conditions for such readmissions to include 4 conditions identified by the MedPAC in its June 2007 *Report to Congress*. The Secretary would also be able to include an appropriate all-condition measure of readmissions. In expanding the list of conditions, the Secretary would be required to seek the endorsement by a consensus-based entity, but would be able to apply such conditions with such endorsement.

The Secretary would be required to monitor activities of applicable hospitals to determine if such hospitals took the steps to avoid patients at risk to reduce the likelihood of increasing readmissions for applicable conditions. If the Secretary determined that such a hospital had taken such steps, the Secretary could impose an appropriate sanction after having provided notice to the hospital and the opportunity for that hospital to alleviate such steps. It is the intent of the Committee that the Secretary would monitor, and impose appropriate sanctions, to hospitals that took inappropriate steps in an effort to avoid the readmissions policy such as transferring patients inappropriately to other hospitals or "planning" inappropriate rehospitalizations.

For fiscal years beginning on or after FY2011, the Secretary would be required to increase DSH payments to targeted hospitals that received $10 million or more in disproportionate share payments in their most recently settled cost report. These targeted hospitals would be required to provide satisfactory assurances that the increased payments would be used for transitional care activities. These would be activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, such as one or more of the following: (1) providing care co-

ordination services to assist in transitions from the targeted hospital to another setting; (2) hiring translators and interpreters; (3) increasing services offered by discharge planners; (4) ensuring that individuals receive a summary of care and medication orders upon discharge; (5) developing a quality improvement plan to assess and remedy preventable readmission rates; and (6) assigning discharged individuals to a medical home; and (7) doing other activities as determined by the Secretary.

The Secretary would estimate the percent of the DSH increase subject to aggregate and hospital-specific caps. In the aggregate, increases would not exceed 5% of the estimated savings that would occur in a fiscal year from hospital readmissions policies described above. For specific hospitals, DSH increases would not exceed the estimated difference in spending that would occur in a fiscal year for a hospital due to the application of the excess readmissions policy. The Secretary would make these additional DSH payments on a lump sum basis, a periodic basis, a claim by claim basis or in any other form deemed appropriate. Not later than 3 years after funds are first made available, GAO would be required to submit a report on the use of such funds.

No administrative or judicial review could be conducted of the determination of the base operating DRG amounts; the methodology for determining the adjustment factor and its various components (excess readmissions ratio, aggregate payments for excess readmissions and aggregate payments for all discharges, applicable conditions, and applicable periods); measures of readmissions; the determination of a targeted hospital for additional DSH payments, the increase in DSH payments, the aggregate DSH cap, the hospital-specific DSH limit, and the form of DSH payment.

Application to Critical Access Hospitals (CAHs)

CAHs would receive reduced payments for preventable hospital readmissions starting for cost reporting periods beginning in FY2012 and in subsequent fiscal years. The adjustment factor for acute care hospitals would be applied. The methodology for determining the adjustment factor, including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmission would not be subject to administrative or judicial review.

Application to Post-Acute Care Providers

The proposal would also reduce Medicare payments on claims from post-acute care providers (skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, and long-term care hospitals) for patients readmitted to an applicable hospital or a CAH within 30 days of an initial discharge from a hospital or a CAH. Payments to post-acute providers would be reduced by 0.996 for the fiscal year or rate year 2011; 0.993 for the fiscal or rate year 2013; and 0.99 for fiscal or rate year 2014. This policy would apply to the discharges or services furnished on or after the first day of the rate year, beginning on or after October 1, 2011.

The Secretary would be required to develop appropriate measures of readmissions rates for post-acute care providers and to submit such measures for endorsement through a consensus-based entity, such as the National Quality Forum. The Secretary would be

required to adopt, expand and apply such measures, in the same manner as for applicable hospitals established earlier in the legislation. To the extent such measures would be adopted, the Secretary would adopt similar payment policies for post-acute providers on or after October 1, 2013 that have been established for applicable hospitals and CAHs earlier in this proposed legislation. Post-acute providers would also be subject to the monitoring and penalties established for applicable hospitals and CAHs earlier in this proposed legislation.

Physicians

The Secretary would be required to conduct a study to determine how this readmissions policy could be applied to physicians and issue a public report no later than one year after enactment. Such approaches would be required to be considered: (1) creating a code (or codes) and budget neutral payment amount(s) under the fee schedule for services furnished by an appropriate physicians who sees an individual within the first week after discharge from a hospital or CAH; (2) developing measures of readmissions rates for individuals treated by physicians; (3) applying a payment reduction for physicians who treat the patient during the initial admissions that results in a readmission; and (4) methods for attributing payments or payment reductions to the appropriate physician or physicians.

Funding

In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there would be appropriated, to the CMS Program Management Account, $25 million for each fiscal year beginning with 2010. Amounts appropriated for a fiscal year would be required to be available until expended.

Reason for Change

Hospital readmissions for Medicare beneficiaries are costly and prevalent. Studies have demonstrated that almost 20% of Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days and accounted for almost $15 billion in spending in a year. A number of interventions at the time of discharge have been shown to decrease the frequency of readmissions. Researchers have suggested that supportive palliative care and increased efforts to coordinate prompt and reliable follow-up care with primary care physicians by hospital providers would reduce readmissions and increase patient satisfaction.

MedPAC has pointed out that high readmission rates sometimes indicate poor care or missed opportunities to better coordinate care. Their report highlights that seven medical and surgical conditions (heart failure, chronic obstructive pulmonary disease, pneumonia, acute myocardial infarction, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, and other vascular procedures) account for almost 30% of readmissions in the 15-day window after discharge. Of these, three measures (heart failure, pneumonia and acute myocardial infarction) have been endorsed by the National Quality Forum (NQF) as risk-adjusted measures for hospital readmission events.

Various factors that may increase readmission rates include medical errors in the initial admission, improper discharge directions regarding medications and follow-up appointments, or inadequate access to follow-up care within the community. However, despite the clinical risk-adjustment of these measures, factors such as cultural paradigms of health, limited English proficiency, health literacy levels, and lack of access to proper follow-up care or medications are factors that may be barriers to lowering readmissions rates and are additive to patient nonadherence to follow-up discharge. Another element that contributes to rehospitalizations is the management of discharged patients by the post-acute care providers such as nursing homes, rehabilitation providers or community providers.

To reduce readmission rates, enhance quality of care and improve coordination during discharge planning, MedPAC has recommended certain policies for the reduction of readmission rates. This provision takes into account the recommendations set forth by MedPAC regarding payment policies pegged to readmission rates. The policy adjusts payments for hospitals, critical access hospitals and hospitals paid under section 1814(b)(3) of the SSA based on the dollar value of each hospital percentage of potentially preventable Medicare readmissions for 3 conditions that have been endorsed by NQF as risk-adjusted readmission measures. It also directs the Secretary to expand the policy to additional conditions in future years and authorizes the Secretary to modify the adjustment based on a hospital's performance in readmission rates compared to a ranking of hospitals nationally.

The policy provides assistance to certain hospitals for transitional care activities to address patient non-adherence issues that may result in high readmission rates. Some of the factors that may contribute to higher rates of admissions and readmissions include (1) patients lack of understanding about medications and directions for follow-up care due to low health literacy levels or limited English proficiency; (2) patients' inability to navigate through a complex tertiary care center to arrange for follow-up appointments for specialists or diagnostic tests; (3) lack of access to medications or providers; and (4) lack of appropriate cultural or linguistic discharge directions.

The above conditions are more prevalent in safety net hospitals and in communities which they serve. Hospitals eligible to receive assistance would receive additional disproportionate share payments and are required to provide transitional care activities to address patient nonadherence issues such as translators for discharge planning and patient education. This provision includes an interim policy for post-acute providers beginning in fiscal year 2012, and directs the Secretary to develop risk-adjusted readmission rates for post-acute providers.

Physicians' role in patient care management also can affect the rate of potentially preventable hospital readmissions. However, the process of determining the responsible provider and accountability for the rehospitalization is complicated. This provision charges the Secretary with evaluating how this policy could be applied to physicians.

Effective Date

October 1, 2011.

Sec. 1152. Post Acute Care Services Payment Reform Plan and Bundling Pilot Program

Current Law

Medicare pays for most post-acute care (PAC) services, including skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and home health, under prospective payment systems (PPS) established for each type of provider. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital discharge or a payment classification group. As some Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of PAC providers, Medicare makes separate payments to each provider for covered services. Payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

The Deficit Reduction Act of 2005 (P.L. 109–171) required the Centers for Medicare and Medicaid Services (CMS) to develop a Post Acute Care Payment Reform Demonstration (PAC demonstration). The goal of this initiative is to standardize patient assessment information from PAC settings and to use these data to guide payment policy in the Medicare program. This demonstration began in 2008 and a report is expected to be submitted to Congress by the Secretary in 2011. CMS has also established a 3–year Acute Care Episode (ACE) Demonstration to test the effects of using a bundled payment for hospital and physician services for a set of 9 orthopedic and 28 cardiovascular conditions. There are 5 participants in the ACE demonstration which began early in 2009.

The Medicare Payment Advisory Commission (MedPAC), among others, has expressed concern that providers do not have financial incentives to coordinate across episodes of care nor to evaluate the full spectrum of care a patient may receive. In its June 2008 report, MedPAC recommended that a bundled payment system for an episode of care where separate payments for distinct types of providers would be eliminated be explored in a pilot program. Under this voluntary program, a single provider entity would receive a bundled payment intended to cover the costs of the full range of care needed over the hospitalization episode, including 30 days post-discharge. The pilot program should have clearly established guidelines for determining whether it should be discontinued or expanded to the entire Medicare program.

Proposed Law

The Secretary would be required to develop a detailed plan to reform payment for Medicare's PAC services, including specifications for a bundled payment, to improve their coordination, quality, and efficiency and outcomes for individuals, such as reducing the need for readmission to hospitals from such PAC providers. For this plan, PAC services would include those services provided by SNFs, IRFs, LTCHs, hospital-based outpatient rehabilitation facilities, and home health agencies to individuals after discharge from a

hospital and such other services as determined appropriate by the Secretary.

The plan would be required to include consideration of the following issues: (1) the nature of payments under a PAC bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services would be included, and the period covered by the bundle; (2) whether the payment should be consolidated with the payment under the inpatient prospective system or a separate payment established for such bundle, and if a separate payment is established, whether it should be made only upon use of PAC services or for every discharge; (3) whether the bundle should be applied across all categories of providers of inpatient services and PAC services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS-DRGs; (4) the extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to be achieved with a bundle payment, whether such rates should be established on a national basis or, for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences; (5) the nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed, as determined by an appropriate assessment instrument, and the extent to which transitional care services would improve quality of care for individuals and the functioning of a bundled post-acute system; (6) the nature of relationships that may be required between hospitals and providers of PAC services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws; (7) quality measures that would be appropriate for reporting by hospitals and post-acute providers; (8) how cost-sharing for a PAC bundle should be treated relative to current rules for cost-sharing for inpatient hospital, home health, skilled nursing facility, and other services; (9) how other programmatic issues should be treated in a PAC bundle; and (10) such other issues as the Secretary would deem appropriate.

In the development of this plan, the Secretary would be required to consult relevant stakeholders and to consider experience with such research studies and demonstrations that the Secretary determines appropriate. In addition, the Secretary would be required to analyze the impacts (including geographic impacts) of PAC reform approaches, including the effect on beneficiaries, hospitals, PAC providers, and physicians; use existing data (such as data submitted on claims) and collect such data as the Secretary would determine appropriate; and if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the Continuity Assessment Record and Evaluation (CARE) tool being developed to measure the health and functional status of Medicare acute discharges and changes in severity and other outcomes for Medicare PAC patients under CMS' PAC demonstration plan.

Out of any funds in the Treasury not otherwise appropriated, there would be appropriated to the Secretary for the CMS Program Management Account $15 million for each of the fiscal years 2010 through 2012. These amounts appropriated for a fiscal years would

be required to be 176 available until expended. Provisions concerning the coordination of federal information policy contained in the U.S. code would not apply.

The Secretary would be required to issue interim public reports on a periodic basis and, not later than 3 years after enactment, issue a final public report on this plan and its impact.

Conversion of Acute Care Episode Demonstration to Pilot Program and Expansion to Include Post-Acute Services

This provision would require the Secretary, by no later than January 1, 2011 and for the purpose of promoting bundled payments to promote efficient and high quality delivery of care, to convert the acute care episode demonstration into a pilot program and expand it to include post-acute services and such other services the Secretary determines to be appropriate (which may include transitional services). Under this pilot program, the Secretary could apply bundled payments to: (i) hospitals and physicians; (ii) hospitals and post-acute-care providers; (iii) hospitals, physicians, and post-acute care providers; or (iv) combinations of post-acute providers. Bundled payments would be applied in manner as to include collaborative care networks and continuing care hospitals.

A collaborative care network would be defined as a consortium of health care providers that would provide a range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality and efficiency of care, increase preventive services, and promote adherence to post-acute and follow-up care plans.

A continuing care hospital would mean an entity that has demonstrated the ability to meet patient care and patient safety standards and that would provide, under common management, the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units, longterm care hospitals, and SNFs that are located in a hospital.

The pilot program could include additional geographic areas and conditions which account for significant program spending, as defined by the Secretary. No number limit would be imposed on hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program. The Secretary would be required to only expand the pilot program if the CMS' Chief Actuary certifies that the demonstration and pilot programs maintain or increase the quality of care received by individuals and such demonstration program and pilot program reduce program expenditures and result in estimated spending that would be less than otherwise. Participation in this pilot program would be voluntary.

The Secretary would be required to conduct an evaluation of the pilot program to study its effect on costs and quality of care. Findings would be included in the final report required under section 1152(e)(2) of America's Affordable Health Choices Act of 2009.

Study of Additional Bundling and Episode-Based Payment for Physicians' Services

The Secretary would also be required to provide a study of and development of a plan to test additional ways to increase bundling of payments for physicians in connection with an episode of care, such as with outpatient hospital services or services rendered in physicians' offices, other than those provided under the pilot program. This plan could be implemented by the Secretary in a demonstration.

Reason for Change

According to MedPAC, the fee-for-service payment system encourages volume growth and fails to encourage care coordination delivered across an episode of care. Ideally, the payment system should incentivize hospitals, post-acute institutions and physicians to collaborate in coordinating care for Medicare beneficiaries and to work efficiently together. However, under the current feefor-service payment structure, each sector of the healthcare delivery system functions independently in terms of delivery of care And with respect to reimbursement of services.

Currently, hospitals are paid a single amount that is based on the patient's diagnosis which covers all hospital costs associated with the stay except for the physician fee portions. Surgeons are also paid a bundled fee called a global surgical fee that includes the post-surgical follow up visits. MedPAC suggests that while these payment innovations may have improved providers' efficiency (e.g. shorter length of stay) during the episode of care, they apply to only one provider and therefore have a limited effect in reducing the aggregate volume of services paid for by Medicare.

Health policy experts have recommended that under a bundled payment structure, Medicare would pay a single provider entity an amount intended to cover the costs of providing a full range of care needed over a hospitalization episode, including the acute care and the post-acute care setting. However, a bundled payment system has significant implications pertaining to future delivery of care for Medicare beneficiaries. Such a broad policy has never been tested for post-acute care services, though the ACE demonstration model has tested the concept with physicians for specific procedures. Issues include: (1) potential reduction of services or "stinting" of care as providers take on greater risk in the system; (2) how payments are consolidated and which entity receives the payment; (3) the quality measures used to evaluate such an innovative payment and delivery of care model; and (4) anti-trust issues as well as other competitive issues as outlined in the provision.

This legislation directs the Secretary to create a payment plan that will consider these critical issues. The Secretary shall also conduct a study on bundling payments for physician services in the outpatient setting that could lead to a demonstration project. The ACE demonstration is extended to evaluate different provider combination entities that would receive a bundled payment and considers a collaborative care network for coordinated care. This provision also directs the Secretary to support Collaborative Care Networks in replicating effective models that reduce avoidable use of emergency rooms for non-urgent care while improving health status and care coordination for vulnerable populations. The new pilot

structure would allow the Secretary to expand the program if budget neutrality and quality of care is maintained or improved.

Effective Date

January 1, 2011.

Sec. 1153. Home Health Payment Update for 2010

Current Law

Home health agencies (HHAs) are paid under a prospective payment system (PPS) that began on October 1, 2000. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. Starting in 2007, HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points. This reduction only applies to the fiscal year in question.

Proposed Law

The provision would eliminate the MB update for home health payments for 2010. Home health agencies would still be subject to the data quality provision for subsequent years.

Reason for Change

This section implements a MedPAC recommendation to freeze payment rates for home health agencies (HHAs) for 2010. Not only do HHAs have extremely healthy Medicare margins—indicating that they are paid significantly above costs—beneficiaries have ample access to HHAs, volume of services continues to rise, quality of care remains largely stable and the entry of new agencies suggests that access to capital is robust. All of these indicators of payment adequacy are positive, and the Committee believes that the freeze in payment rates will not adversely affect beneficiary access to or quality of home health care.

Effective Date

January 1, 2010.

Sec. 1154. Payment Adjustments for Home Health Care

Current Law

Home health agencies (HHAs) are paid under a prospective payment system (PPS). Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS. The base payment amount, or national standardized

60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points for that fiscal year.

In calendar year (CY) 2008, CMS made refinements to the home health (HH) PPS to try to improve payment efficiencies. These refinements included a reduction in the national standardized 60-day episode payment rate for 4 years to account for changes in case mix that are not related to HH patients' actual clinical conditions; changes to the case-mix model to account differently for comorbidities and the differing health characteristics of longer-stay patients, including increasing the HH resource groups from 80 to 153 case mix groups; changes to the way the PPS accounts for the impact of rehabilitation services on resource use to reduce the impact of financial incentives on the delivery of therapy visits; and an increased payment for low utilization payment adjustment (LUPA) episodes that occur as the only episode or the first episode during a period of HH to account for front-loading of costs; among other changes. These refinements resulted in payment reductions described in Federal Regulation § 484.220 issued on Aug. 29, 2007 (72 FR 49879).

Specifically, this regulation established changes to the HHA case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY 2008; by 2.75% for each year of CY 2009 and CY 2010, and by 2.71% and for CY 2011.

Proposed Law

The provision would accelerate the case-mix adjustments described in 42 FR § 484.220 by implementing both the planned CY 2011 adjustment of 2.71% and the planned CY 2010 of 2.75% at the same time in CY 2010, for a total CY2010 downward adjustment of 5.46%. The 180 amounts of these adjustments would not be limited if more recent data were to indicate that a greater adjustment would be appropriate.

Starting in 2011, HH prospective payment amounts would be adjusted by a uniform percentage determined appropriate by the Secretary and based on analysis of factors such as changes in the average number and types of visits in an episode, changes in the intensity of visits in an episode, growth in cost per episodes, and other factors that the Secretary would consider to be relevant. For years after 2011, such amounts would be required to be equal to the amount paid for the previous year updated by the HH market basket.

If the Secretary is not able to compute the changed prospective payment amounts for 2011 on a timely basis, then the Secretary would be required to pay 95% of what the prospective payment amount would have been had this provision not applied. And, under such circumstances, the Secretary would be required to compare, before July 1, 2011, amounts paid to the amount that would

have been paid had the Secretary been able to compute the adjustment on a timely basis. For 2012, the Secretary would be required to decrease or increase the prospective payment amount (or at the Secretary's discretion, over a period of several years beginning with 2012), by the amount (if any) by which the amount applied is greater or less, respectively, than the amount that should have been applied.

Reason for Change

Nine percent of Medicare beneficiaries used home health services in 2007, an increase of 23 percent since 2002, and Medicare spending on home health services grew 12 percent from 2006, to $16 billion. Home health agencies (HHAs) have Medicare margins of almost 17 percent, suggesting that Medicare payments significantly exceed costs for agencies. Ninety-seven percent of Medicare beneficiaries live in areas served by two or more HHAs. MedPAC concludes that agencies should be able to absorb cost increases without an increase in base payments and without negative effects on beneficiary access to care or quality of treatment.

This section would implement a MedPAC recommendation to reduce payments to HHAs in FY2010 and advance a planned payment reduction for FY2011. These payment reductions will bring Medicare payments more in line with costs, restoring payment accuracy fiscal responsibility to home health payments. Given currently robust beneficiary access to care at home health agencies, the Committee is confident that these payment reductions will not adversely affect access to care.

One source of Medicare overpayments to HHAs results from an assumption in the payment rates that agencies provide 32 visits per 60-day episode. However, this measurement is based on data from 1998; since then, the number of visits per episode has dropped by 30 percent, to an average of 22 visits. Other changes in utilization of home health—such as types of visits, intensity of visits, growth in cost per episode—affect payment rates, and the Committee intends that those rates should be updated to reflect more recent data. MedPAC advises that rebasing payments to providers' actual costs will limit exorbitant profit margins and help restore efficiency to the home health sector.

Recognizing that the Secretary may not be able to complete the rebasing analysis in a timely fashion to implement for 2011—but also that absent a payment change in addition to the annual updates, HHAs will continue to be overpaid by the Medicare program—the Committee intends that the Secretary implement a fallback payment adjustment if the rebasing analysis is not complete. This would ensure that fiscal responsibility is restored to the home health sector.

Effective Date

January 1, 2010.

Sec. 1155. Incorporating Productivity Improvements Into Market Basket Update For Home Health Services

Current Law

Home health agencies (HHAs) are paid under a prospective payment system (PPS) based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS.

The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points.

Each year, the Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations for the different payment systems. In its view, Medicare's payment systems should encourage efficiency: providers should be able to reduce the quantity of inputs to produce a unit of service while maintaining quality. Accordingly, MedPAC begins its update deliberations with an assumption that all providers can achieve efficiency gains similar to the economy and examines the Bureau of Labor Statistics' estimate of the 10-year moving average rate of past growth in total factor productivity for the economy as a whole. This policy target links Medicare's expectations for efficiency improvements to the productivity gains achieved by firms and workers who pay taxes that fund Medicare. MedPAC's annual update recommendation will depend on its overall assessment of the circumstances of a given set of providers in any year. These MedPAC recommendations are not binding on Medicare payment policies.

Proposed Law

The provision would make annual updates by the HH MB subject to a productivity adjustment as long as the annual update would not be less than zero. The productivity adjustment would equal the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. The estimate used would be that published before the promulgation of the regulation establishing the Medicare rates for the year or period. This provision would be required to apply to home health market basket percentage increases for years beginning with 2010.

Reason for Change

The annual update to the Medicare physician fee schedule already incorporates adjustments for gains in productivity. This provision creates uniformity across Medicare providers by creating a productivity adjustment for home health agencies. This adjustment will encourage greater efficiency in health care provision, hold Medicare providers accountable for achieving productivity gains on par with the overall economy, and more accurately align Medicare payments with provider costs.

Effective Date

January 1, 2010.

Sec. 1156. Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals

Current Law

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of designated health services to individuals residing in rural areas are exempt as well.

Entities receiving Medicare payment for covered items and services are required to provide the information on the entities' ownership, investment, and compensation arrangements. This information includes the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or those whose immediate relatives) who have an ownership or investment interest, or certain compensation arrangements.

Proposed Law

Only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals (including rural providers) that have physician ownership and a provider agreement in operation on January 1, 2009 and that met other specified reporting and disclosure requirements would be exempt from this self-referral ban. Hospitals would be allowed to maintain the percentage of the total ownership or investment held in the hospital (or in an entity whose assets include the hospital) by physician owners or investors in the aggregate at the level that existed as of date of enactment. Hospitals would be allowed to expand the number of operating rooms, procedure rooms, or beds of the hospital if certain criteria are met. The hospital could not have converted from an ambulatory surgical center to a hospital after enactment.

To qualify for the self-referral exemption, entities receiving Medicare payment for covered items and services would be required to provide the information on the entities' ownership, investment, and compensation arrangements. This information would include the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or those with immediate relatives) who have an ownership or investment interest, or certain compensation arrangements. Such information would be provided in the form, manner, and at such times as specified. This requirement would not apply to designated health services provided outside of the United States or to entities deemed to provide infrequent services paid by Medicare.

An exempt entity would also be required to (1) submit an initial report and periodic updates at specified intervals that contain a detailed description of the identity of each physician owner and investor as well as any other owners and investors in the hospital, and any other information on the nature and extent of all ownership in-

terests in the hospital; (2) disclose to each patient of any referring physician owner or investor (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the treating physician; and (3) disclose the fact that the hospital is partially or wholly owned by one or more physician investors on any public website for the hospital and in any public advertising for the hospital. This requirement would not apply to designated health services provided outside of the United States or to entities deemed to provide infrequent services paid by Medicare. Information provided by hospitals would be published and periodically updated on the Internet website of the Centers for Medicare and Medicaid Services (CMS). Any person who fails to meet required reporting and disclosure requirements would be subject to a civil monetary penalty of not more than $10,000 for each day for which reporting is required to have been made or for each case in which disclosure is required to have been made.

Exempt hospitals would ensure bona fide ownership and investment by meeting the following requirements (1) any ownership or investment interest offered to a physician could not be offered on more favorable terms than those offered to a person who is not in a position to refer patients or otherwise generate hospital business; (2) the hospital (or investors in the hospital) could not directly or indirectly provide loans or financing for physician owners or investors in the hospital; (3) the hospital or its investors could not guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual physician owner, investor, group of physician owners or investors that is related to acquiring an ownership or investment interest in the hospital; (4) ownership or investment returns would have to be distributed to investors in the hospital in an amount that is directly proportional to the investment or ownership by the hospital investor; (5) the investment interest of the owner or investor would be required to be directly proportional to the capital contributions made at the time the ownership or investment interest is obtained; (6) physician owners and investors could not receive any guaranteed receipt or right to purchase other business related interests in the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital; (7) the hospital could not offer a physician owner the opportunity to purchase or lease any property under hospital control on more favorable terms than those offered to others and (8) the hospital could not condition any physician ownership or investment interests on the physician making or influencing referrals to the hospital or generating business for the hospital.

To ensure patient safety, those exempt hospitals that do not offer emergency services would have to have the capacity to (1) provide assessment and initial treatment for medical emergencies; and (2) refer and transfer the patient with the medical emergency to a hospital with the required capability if the exempt hospital lacks the capabilities to treat the involved emergency. Those hospitals that do not have any physician available on the premises 24 hours per day, 7 days a week would have to disclose such a fact to the patient before admitting the patient. Following such a disclosure, the hospital would receive a signed acknowledgement from the patient

that the patient understands that fact. The Secretary would retain the ability to terminate a hospital's provider agreement if the hospital is not in compliance with Medicare's conditions of participation.

Exempt hospitals would be permitted to increase the number of operating rooms, procedure rooms or beds after the date of enactment under certain criteria. A procedure room includes a room in which catheterizations, angiographies, angiograms, and endoscopies are furnished. This would not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished). Hospitals meeting certain criteria would be allowed to expand, with these criteria including (1) a hospital that is located in a county where the population increased during the most recent 5 year period at a rate that is at least 150% of the State's population increase; (2) a hospital whose Medicaid inpatient admission percentage is equal to or greater than average percentage for all hospitals located in the county; (3) a hospital that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) a hospital that is located in a State with an average bed capacity less than the national average; (5) a hospital that has an average bed occupancy rate that is greater than the State average bed occupancy rate; and (6) meets other established requirements.

This capacity increase would be limited to facilities on the main campus of the hospital and could not exceed 200% of the number of operating rooms, procedure rooms and beds at the time of enactment. The process for expansion should allow the opportunity for community input and should permit an applicable hospital to apply for the expansion exception up to once every two years. The Secretary would be required to promulgate regulations establishing an appeals process no later than the first day of the month beginning 18 months after the date of enactment. The appeals process would be implemented one month after the date of regulations are promulgated. These regulations could be issued as interim final regulations. The final decision regarding an expansion request should be posted on the CMS website no later than 120 days after a complete application is received. There would be no administrative or judicial review of this process.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements. Enforcement efforts could include unannounced site reviews of hospitals. In addition to funds otherwise available, starting in FY2010, $5 million would be appropriated in each fiscal year from not otherwise appropriated funds in the Treasury for purposes of carrying out this section. Appropriated funds would be available until expended. Certain federal laws with respect to the coordination of federal information policy established by Chapter 35 of Title 44 of the United States Code would not apply to these requirements.

Reason for Change

When originally enacted, the physician self-referral laws included an allowance for physicians to have ownership in a whole hospital. It was included because, at the time, there were a number of rural

hospitals in particular where such ownership arrangements were in effect. Ownership in a whole hospital was not then viewed as a significant incentive for self-referral because these hospitals were usually the only hospitals in the area and they provided a breadth of services. The original physician self-referral law did explicitly prohibit ownership in "a subdivision of a hospital" because of the concern that if physicians owned only their particular part of a hospital—like a cardiac wing—there would be an incentive for self-referral.

Since enactment of the self-referral laws, entities have been created that identify and license themselves as "hospitals" under state law. However, many of these facilities no longer provide the full range of services a layperson would expect from a hospital. Instead, they limit their services to a narrow band of services. These bands have also tended to be profit centers for hospitals—most commonly cardiac procedures and orthopedic procedures. In effect, they've taken a "subdivision of a hospital" and made it a free-standing hospital in order to circumvent the prohibition in the physician self-referral laws which prohibit self-referral when the ownership is "merely in a subdivision of a hospital."

There have also been a number of facilities that have converted from ambulatory surgical centers to hospitals. These entities may provide more than one subset of services and appear to look more like a typical hospital, but they too often focus on high-profit services, fail to have fully-staffed emergency rooms, and treat low percentages of Medicaid patients or uncompensated care patients compared to other hospitals in their communities.

Many of these new physician-owned hospitals are called "specialty hospitals" or "limited service hospitals". The Medicare Payment Advisory Commission and other experts have studied these facilities and raised concerns that they result in unnecessary procedures, increasing health care spending, and selecting more profitable patients. In a report to Congress, MedPAC found that "entrance of a physician owned cardiac hospital was associated with a 6% increase in the number of cardiac surgeries per 1000 patients." They also found that the profit margins for these facilities far exceed those of full-service community hospitals—averaging 34% return on capital at the average orthopedic hospital. Finally, MedPAC raised concerns that these facilities focus on patients with private insurance, low-severity cases, and perform many outpatient services at these facilities where they get reimbursed at a higher rate than would an ambulatory surgical center which can also safely perform these services.

In the past several years, there have been at least three publicized instances in which patients have died in these facilities because there was no doctor to provide care when they had complications post-surgery.

While most research has focused on the specialty hospitals, concerns are being raised about physician ownership of any hospital. Recently, a highly regarded surgeon and health policy expert, Dr. Atul Gawande, wrote an article in the New Yorker about the medical care provided in McAllen, Texas, one of the poorest counties in our nation, yet is second only to Miami, Florida in health care spending. Referring to a new physician-owned hospital in the county, Dr. Gawande writes:

> It is the newest hospital in the area. It is physician-owned. And it has a reputation (which it disclaims) for aggressively recruiting high-volume physicians to become investors and send patients there. Physicians who do so receive not only their fee for whatever service they provide but also a percentage of the hospital's profits from the tests, surgery, or other care patients are given. (In 2007, its profits totaled thirty-four million dollars.) Romero and others argued that this gives physicians an unholy temptation to overorder.

It is no longer the case that most rural community hospitals have financial arrangements that include physician ownership. Given that change, and the concern about self-referral to these physician-owned hospitals, this provision eliminates the whole hospital exception all together. The provision grandfathers existing facilities if they are willing to meet a strong set of financial and quality standards going forward. This provision also allows for growth of the hospital in circumstances of community need.

The Committee notes that Congress has been confronting concerns about physician-owned hospitals for most of the decade. The Medicare Modernization Act of 2003 enacted a temporary moratorium on the entrance of new physician-owned specialty hospitals into the Medicare program.

Since then, the House has passed legislation to prohibit physician self-referrals to hospitals in which they have ownership three times. In its original inception, passed as part of the Children's Health and Medicare Protection Act on August 1, 2007 (H.R. 3162 in 110th Congress), the provision would have required most physician-owned hospitals to restructure their ownership arrangements in order to continue participating in Medicare. It would have limited aggregate physician ownership to forty percent of the hospital and limited individual ownerships to two percent. In addition, it would have prohibited any growth of the facilities that were allowed to continue with this more limited ownership arrangement. That provision was scored by the Congressional Budget Office as saving $2.9 billion over 10 years.

The House next passed a similar provision on March 5, 2008 as a financing mechanism for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. That version was modified from the original language and the savings reduced to $2.4 billion over 10 years. The Senate passed a further revised provision on May 22, 2008 as part of the Iraq Supplemental legislation. The House most recently passed a version very similar to the Senate as part of the CHIP Reauthorization Act on January 14, 2009. The savings were reduced to $1.2 billion due to the passage of time and modifications that had been made in the Senate. The provisions in H.R. 3200 are similar to that bill, with changes only reflecting technical improvements, and savings are now only $1 billion over 10 years.

As Congress has grappled with this issue during the last several years, modifications have been made to address the concerns of existing physician-owned hospitals. As drafted, the bill protects all physician-owned hospitals that were participating in Medicare as of January 1, 2009. That date is the same as the legislation passed earlier this Congress. It also modifies the original language by per-

mitting them to pursue limited growth when there is clear community need.

Effective Date

Date of enactment.

Sec. 1157. Institute of Medicine Study of Geographic Adjustment Factors Under Medicare

Current Law

Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. For example, Medicare's physician fee schedule (which with modifications is used to reimburse other health care practitioners) uses the geographic practice cost index (GPCI) for this purpose; Medicare's inpatient prospective payment system (IPPS) uses a hospital wage index to adjust payments for acute care hospitals. With modifications, the IPPS wage index is used to calculate payments for inpatient rehabilitation hospitals, inpatient psychiatric hospitals, long term care hospitals, skilled nursing facilities, and home health agencies.

Proposed Law

The Secretary would enter into a contract with the Institutes of Medicine of the National Academy of Sciences (IOM) to conduct a comprehensive empirical study with appropriate recommendations on the accuracy of the geographic adjustment factors established for Medicare's physician fee schedule and for Medicare's IPPS. The study would include an evaluation of the empirical validity of the adjustments, methodology used to determine the adjustments, and measures used for the adjustments. The latter would take into account the timeliness of the data and frequency of data revisions, data sources and validity, and operational costs of participating providers. The study would also examine the effect of the adjustment factors on the level and distribution of the health workforce within the United States. This would include the recruitment and retention accounting for workforce mobility between urban and rural areas; ability of hospital and other facilities to maintain an adequate and skilled workforce; patient access to providers and needed medical technology. The study would also examine the effect of the adjustment factors on population health and quality of care and the ability of providers to furnish efficient, high-value care. The IOM report would be submitted to the Secretary and to Congress no later than one year from enactment. Necessary funds would be authorized to be appropriated to carry out this study.

Reason for Change

This provision addresses concerns about the methodology and data used to geographically adjust Medicare payment rates. Such adjustments, which are mandated by the Social Security Act, are intended to reflect geographic differences in input costs faced by practitioners and hospitals, such as wage rates, overhead costs, rent, and malpractice insurance. The IOM will conduct an empirical study into whether CMS is using valid methods and data to make these adjustments, and directs IOM to take factors such as

provider recruitment and retention into consideration. To the extent this study finds that the methods and data being used to make these adjustments are not optimal or appropriate, IOM is directed to make recommendations on changes.

Effective Date

Date of enactment.

Sec. 1158. Revision of Medicare Payment Systems to Address Geographic Inequities

Current Law

Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. In the previous section, IOM is required to conduct a study of the geographic practice cost index (GPCI) used to adjust Medicare's physician fee schedule and the hospital wage index used in Medicare's inpatient prospective payment system (IPPS). With modifications, Medicare's physician fee schedule and the hospital wage index are used to reimburse other practitioners and providers.

Generally, the Centers for Medicare and Medicare Services promulgates changes to Medicare's physician fee schedule and IPPS through an annual rulemaking process where proposed changes and a notice of a public comment period are published in the Federal Register with the final rule establishing the payment polices and responding to the public comments issued subsequently in the Federal Register. Medicare's IPPS and physician payments are on different payment years and therefore rulemaking schedules. Generally the new IPPS payment rates are effective October 1st of each year and new physician fee schedule is effective as of January 1st of each year.

Proposed Law

The Secretary would be required to take into account the IOM recommendations included in their report on the adequacy of Medicare's geographic adjustments established in the previous section. Appropriate proposals to revise the respective geographic adjustments would be included in the proposed rules applicable to the rulemaking process for Medicare's payments for physicians' services and IPPS hospitals. The proposals would be included in the next applicable rulemaking cycle after submission of the IOM report to the Secretary. The Secretary would be able to change the geographic adjustments accordingly, but could not reduce an adjustment below that which applied in the payment system in the prior payment year. These adjustments for services furnished before January 1, 2014 could not exceed the amounts in the Medicare Improvement Fund as amended in this legislation. No more than half of that $8 billion would be available in any one payment year.

Reason for Change

Any recommendations made by the IOM in the study mandated by section 1157 must be immediately taken into account by CMS. The study under section 1157 is intended to improve the methods and data used by CMS to adjust Medicare payment rates for practi-

tioners and hospitals for geographic differences in input costs. To the extent that such recommendations result in payment rates being increased, $4 billion a year for two years is provided to fund additional spending resulting from the rate increases in any area. To facilitate the transition to revised payment adjustments, payment rates may not be decreased as a result of the study's recommendations for a period of two years. After the two-year transition period, payment rates will be adjusted on a budget neutral basis.

Effective Date

Date of enactment.

Sec. 1159. Institute of Medicine Study of Geographic Variation in Health Care Spending and Promoting High-Value Health Care

Current Law

No current law. Significant geographic variation in the medical spending has been well documented in the health care literature. However, the underlying causes of these spending differences, but more importantly, the appropriate policy responses to such variation has been the subject of much debate.

Proposed Law

The Secretary would enter into an agreement with the Institutes of Medicine (IOM) to conduct a study on the geographic variation of per capita health spending among both the Medicare and privately insured populations. The studies would include evaluations of (1) the extent and range of such variation using various units of geographic measurement; (2) the extent to which geographic variation can be attributed to differences in input prices, practice patterns, access to medical services, supply of medical services, socioeconomic factors, and provider organizational models; (3) the extent to which variation are correlated with patient access to care, distribution of health care resources and consensus-based measures of health care quality; (4) the extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which these discretionary treatment decisions are made without regard to the best available medical evidence; (5) the degree to which variation cannot be explained by empirical evidence; and (6) other appropriate factors.

IOM would recommend strategies for addressing variation in per capita spending by promoting high-value care, by considering measurement and reporting on quality and population health, reducing fragmented and duplicative care; promoting the practice of evidence-based medicine; empowering patients to make value-based medical decisions; leveraging the use of health information technology, the role of financial and other incentives as well as other appropriate topics. High-value care would be defined as the efficient delivery of high quality, evidence-based, patient-centered care.

In making the recommendations, IOM would address whether Medicare's physician and hospital payment systems should be further modified to provide incentives for high-value care. IOM would consider the adoption of a value based index based on a composite

of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If adoption is deemed appropriate, IOM would make specific recommendation on the design and implementation of the index, including the identification of specific measures of quality and cost and a thorough analysis of how Medicare payments and spending on a geographic basis would be affected. The IOM report would be submitted to Congress no later than 3 years after the date of enactment. Necessary sums to conduct the study would be authorized to be appropriated.

Reason for Change

The Committee is interested in knowing more about variation in the utilization of health care services throughout the country. Studies indicate there is a significant amount of variation in health care spending between different regions of the country, as well as between providers within each region. This provision will direct IOM to conduct a thorough empirical examination of variation in health care spending attributable to differences in utilization patterns rather than in payment rates or special payments that are largely unrelated to care for individual patients.

The study under this section is intended to provide a better understanding of how much and why utilization varies from provider-to-provider and region-to-region. This will help shed light on the extent to which variation can be attributed to differences in patient health status, socio-economic factors, patient compliance or other similar factors that are largely outside the control of providers. It will also look at variation in treatment patterns that can be traced to the discretion of individual providers, and whether such variation is justified or, as some analysts have contended, represent provision of services that do not result in improved health outcomes.

Taking the findings of this study into account, the IOM is directed to consider whether Medicare's payment systems should be changed to better incentivize the delivery of high-value health care. To the extent that IOM finds Medicare's payment systems should be changed, it is directed to make specific recommendations on how to do so. In making any recommendations, IOM should consider a "value index" approach that would adjust payment rates according to measures of quality and per-capita spending, but IOM is not required to recommend use of the value index. Furthermore, it is the Committee's intent that any recommendations be directed toward changing the way Medicare pays for care and should not include changes to special programs designed to achieve specific policy goals, such as payments for graduate medical education, indirect medical education, and health information technology. This approach is consistent with legislation introduced in the House to institute a value index adjustment in the Medicare program.

To maximize the utility and reliability of the study and any recommendations, the study should be conducted by individuals who have a wide and balanced range of expertise in areas such as clinical medicine, economics, academic medicine, and health care management. The Committee also urges IOM to make recommendations that are consistent with the core goals of the Medicare program to provide accessible, affordable health care to every Medi-

care beneficiary. As such, to the extent the IOM recommends substantial payment changes, the IOM report shall include an appropriate phase-in that takes into account the impact of such changes on providers and facilities and preserves access to care for Medicare beneficiaries.

Effective Date

Date of enactment.

Subtitle D—Medicare Advantage Reforms

Part 1—Payment and Administration

Sec. 1161. Phase-in of Payment Based on Fee-for-Service Costs

Current Law

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Beginning in 2006, the Secretary began determining MA payment rates by comparing plan *bids* to a *benchmark*. Each bid represents the plan's estimated revenue requirement for providing required Parts A and B Medicare services to an average Medicare beneficiary. The benchmark amounts represent the maximum amount the federal government will pay a plan for providing required Medicare benefits. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75% of the difference between the benchmark and the bid. The rebate must be used to provide additional benefits, reduce enrollees' Medicare cost sharing expenses, or reduce enrollees' monthly Part B, Part D, or supplemental premiums (for services beyond required Medicare benefits). The remaining 25% of the difference is retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment is equal to the benchmark amount, and each enrollee in that plan will pay an additional premium equal to the amount by which the bid exceeds the benchmark.

In general, the MA benchmarks in each local area (county) are updated annually by the overall growth in Medicare expenditures, otherwise known as the National MA Growth Percentage. In certain years (known as *rebasing* years), plan payments are updated by the greater of the growth percentage or 100% of fee-for-service (FFS) costs, with adjustments. Beginning in 2010, the benchmarks are adjusted to phase-out the value of indirect medical education costs.

MA benchmarks are based, in part, on historical Medicare private plan payment rates. The Balanced Budget Act of 1997 (P.L. 105–33, BBA) increased payments to private plans above rates of per capita FFS costs in some areas. Subsequent legislation also increased payment rates to private plans. The historical payment rates were used as the basis for the benchmark amounts, as specified in the Medicare Prescription Drug, Improvements, and Modernization Act of 2003, (P.L. 108–173, MMA). As a result, current MA benchmarks exceed per capita FFS costs in almost all areas.

Proposed Law

Starting in 2011, the provision would phase-in MA benchmarks equal to per capita FFS spending in each county. Starting in 2013, MA benchmarks would be equal to per capita FFS spending in each county. In no event would a benchmark be less than per capita FFS spending. This provision would not apply to Programs of All-Inclusive Care for the Elderly (PACE).

Reason for Change

Private plans were initially included in the Medicare program to test whether managed care would improve efficiency and innovation and reduce costs, especially in parts of the country where traditional, or fee-for-service (FFS), Medicare was an inefficient purchaser. Reflecting this goal, Medicare Health Maintenance Organizations were originally paid at 95 percent of the average adjusted per capita costs (AAPCC) in fee-for-service Medicare at the county level. New Medicare policies enacted in 1997, 2000, and 2003 now result in overpayments to Medicare Advantage (MA) plans. The Medicare Payment Advisory Commission (MedPAC) estimates that, on average, payments to plans are 14 percent higher than costs in fee-for-service Medicare in 2009. The current MA payment system encourages participation of inefficient private plans and unnecessarily drives up costs to the Medicare program.

Overpayments to MA plans exceed $1,000 per MA enrollee per year and MedPAC estimates that in 2009, the Medicare program will pay MA plans $12 billion more for their enrollees than if the same enrollees were in traditional Medicare. These overpayments increase all Medicare beneficiaries' Part B premiums by $4 per month, and cause the Part A Trust Fund to become insolvent a year and a half sooner than it otherwise would. The fact and amount of overpayments to MA plans are indisputable. CBO, MedPAC and others have documented these amounts in testimony before the Committee and in numerous reports. MedPAC has recommended since 2001 that overpayments to MA plans be eliminated and advises that the Congress establish a level playing field where MA plans are paid the same—not more but not less—than the cost for the same beneficiaries in traditional Medicare.

Phasing MA payments down to FFS costs in each county over three years gives MA plans time to adjust, if necessary, to the new payment rates. This policy simply returns to the way that plans used to be paid, based on local FFS costs, or the cost of doing business. Private plans that can achieve efficiencies greater than traditional Medicare—such as HMOs which on average project their costs at 98 percent of the cost of traditional Medicare—are rewarded with a rebate to offer extra benefits to their enrollees. Private plans that are inefficient relative to traditional Medicare should not be subsidized by taxpayers and other Medicare beneficiaries. The phase-out of overpayments to MA plans would result in savings to the Medicare program and taxpayers of $48 billion over five years and $156 billion over 10 years.

The phase-down of MA payments to FFS costs applies equally to all 50 states and the territories, however, Puerto Rico is a unique situation that the Committee expects that the Secretary will use authority under current law to examine. Specifically, very few Medicare beneficiaries in Puerto Rico choose to enroll in Part B; in-

stead, MA plans buy down the Part B premium for enrollees and therefore many Medicare beneficiaries enroll in MA to receive all of their Medicare services.

With only a small population enrolled in Part B through traditional Medicare, the county FFS expenditures calculated by the Secretary are artificially low and unstable from year-to-year. Therefore, the Committee expects that when calculating county FFS rates for Puerto Rico, the Secretary will use utilization and expenditure data from MA plans under current authority and adjust these rates and risk scores appropriately.

The Program for All-Inclusive Care for the Elderly (PACE) is a very small program in Medicare that covers the most frail elderly beneficiaries who would otherwise be in nursing homes. Unlike other MA plans, PACE providers fully integrate Medicare and Medicaid benefits, including long-term care. They are also unable to alter benefits or raise premiums on their beneficiaries. Because of its unique nature, the PACE programs would continue to be paid at current levels.

Effective Date

January 1, 2011.

Sec. 1162. Quality Bonus Payments

Current Law

No provision.

Proposed Law

For plan years starting with 2011, a qualifying plan in a qualifying county would receive an increase in their benchmark amounts equal to 2.6% in 2011, 5.3% in 2012 and 8.0% in subsequent years.

A qualifying plan would be defined as a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system established by CMS) of 4 stars or higher. A qualifying county would be defined as a county, for a year, (a) that was within the lowest quarter of counties with respect to per capita spending in original Medicare, and (b) within which, 50 percent of individuals were enrolled in MA and of the residents enrolled, at least 50 percent were enrolled in a plan with a quality ranking of 4 stars or higher. Starting in 2010, the Secretary would be required to notify the qualifying MA organization that is offering a qualified plan in a qualifying county of their status through the annual announcement of benchmark rates and through publication on the Medicare program website. The Secretary would have the authority to disqualify a plan if the Secretary identifies deficiencies in the plan's compliance with MA rules under this part.

Reason for Change

In certain areas of the country, MA plans have achieved a high penetration rate and have received high quality ratings from CMS. Both criteria indicate that plans are offering beneficiaries a valuable benefit and have high patient satisfaction; low FFS spending in the same area may also indicate that efficiencies gained by the MA plans have spilled over into the traditional Medicare program.

Effective Date

January 1, 2011.

Sec. 1163. Extension of Secretarial Coding Intensity Adjustment Authority

Current Law

In general, Medicare payments to MA plans are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses. The Deficit Reduction Act of 2005 (Pl. 109–171, DRA) required the Secretary, when risk adjusting payments to MA plans during 2008, 2009, and 2010, to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare, to the extent that the Secretary identified such differences based on an analysis of data submitted for 2004 and subsequent years.

Proposed Law

The provision would extend the requirement that MA plan payments be adjusted for differences in coding patterns beyond 2010. The provision would require the Secretary to conduct analyses of coding differences periodically and incorporate the findings on a timely basis.

Reason for Change

When the Deficit Reduction Act gave the Secretary explicit authority to adjust MA payment rates to account for differences in the intensity of diagnosis codes between MA and traditional Medicare that are attributable to inaccurate coding, it limited this authority to three years. For two out of the three years, CMS studied and identified a difference in coding intensity, yet did not adjust MA payments to account for this difference. For 2010, CMS will make a downward adjustment to all MA plan payments to account for its findings of inaccurate coding. While the MA payment system appropriately pays more to plans that enroll a riskier population, CMS' finding suggests that MA plans assign more severe risk codes than the same beneficiary would be assigned in traditional Medicare, possibly increasing the plan payment without clinical justification. Giving the Secretary permanent authority to address this inequity allows the Agency to make appropriate and accurate payments to MA plans, and discourages any practice of "upcoding".

Effective Date

Date of enactment.

Sec. 1164. Simplification of Annual Beneficiary Election Periods

Current Law

Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year (the annual, coordinated election period). Changes go into effect January 1st of the next year. During the first three months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. This period is known as the continuous open enrollment and disenrollment period. However, during the three-month period, beneficiaries cannot change their drug coverage.

Proposed Law

The provision would move the annual, coordinated election period to 15 days earlier in the year—November 1st to December 15th, rather than from November 15th to December 30th. The provision would eliminate the continuous open enrollment and disenrollment period (during the first three months of the year.)

Reason for Change

The current annual election period, from November 15 through December 31, gives MA and Part D plans very little, if any, time to process enrollment requests and ensure that on January 1, each beneficiary is properly enrolled in the plan. Allowing for a two-week processing period between the end of the annual election period and the start of the plan year better ensures that enrollees do not experience any gaps in coverage, and that plans are able to process enrollments in time for the start of the plan year.

The open enrollment period has been a source of confusion for beneficiaries and very few have chosen to take advantage of this three-month opportunity. Only one out of every five annual enrollments takes place during the open enrollment period, even though it is twice as long as the annual election period. Though it was originally conceived of as a beneficiary protection, giving enrollees an opportunity to switch plans after the year began if they discovered a problem with their plan, the confusing restrictions on which plans enrollees are permitted to switch into have severely limited its utility. Moreover, other sections of this bill and CMS have established numerous special enrollment periods that allow enrollees to switch plans if they have exceptional circumstances.

Effective Date

January 1, 2011.

Sec. 1165. Extension of Reasonable Cost Contracts

Current Law

Reasonable Cost plans are MA plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act (P.L. 97–248, TEFRA) of 1982. Balanced Budget Act of 1997 (P.L. 105–33, BBA) included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through Congressional action. These plans are allowed to operate

indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if (1) during the entire previous year there were either two or more MA regional plans *or* two or more MA local plans in the service area offered by different MA organizations; *and* (2) these regional or local plans meet minimum enrollment requirements.

Proposed Law

This provision would extend for two years—from January 1, 2010, to January 1, 2012—the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. The provision would modify the minimum enrollment requirement used as one of the criteria the Secretary considers when determining whether to renew or extend a reasonable cost plan. The enrollment criteria would apply to the portion of the MA regional or local plan's service area for the year that it was within the service area of the reasonable cost contract (and not the total service area of the MA regional or local plan).

Reason for Change

Cost plan enrollees are older than the average Medicare beneficiary and are particularly vulnerable to the type of confusion that results from Medicare program changes. Extending cost plan authority through 2011 will ensure that Cost plan beneficiaries—many of whom have been in their plans for years—can maintain a stable Medicare health plan choice. This provision also clarifies Congressional intent with regard to how CMS counts enrollment for the purpose of prohibiting new Cost plans.

Effective Date

Date of enactment.

Sec. 1166. Limitation of Waiver Authority for Employer Group Plans

Current Law

The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. Such plans can be offered either under contracts between the union or employer group and a Medicare Advantage organization, or directly by the employer or union group.

Proposed Law

For employers or unions that sponsor an MA plan directly and for employers that contract with a private MA organization, the Secretary would only have authority to waive or modify MA requirements for the plan if 90% of eligible individuals enrolled in the plan live in a county in which the MA organization offers an MA local plan. This provision would apply to plan years on or after January 1, 2011. The provision would not apply to plans in effect as of December 31, 2010.

Reason for Change

The MMA gave broad authority to CMS to waive virtually any requirement in order to encourage employers to provide retiree coverage through Medicare Advantage. While some requirements of MA plans marketing in the individual market may not be applicable to employers contracting with or offering an MA plan, and can appropriately be waived, it is crucial that retirees enrolling in such an MA plan have adequate access to a provider network. Requiring that MA plans offer local plans alongside employer group plans ensures that they are meeting network adequacy requirements and enrollees are protected.

Effective Date

January 1, 2011.

Sec. 1167. Improving Risk Adjustment for MA Payments

Current Law

In general, Medicare payments to MA plans are risk adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses, and differences in coding practices between MA and providers under Medicare Part A and B.

Proposed Law

Not later than 1 year after enactment, the Secretary would be required to submit a report to Congress evaluating the adequacy of the Medicare Advantage risk adjustment system at predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries. The report would also be required to address the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data. Taking this report into account, not later than January 1, 2012, the Secretary would be required to implement necessary improvements to the MA risk adjustment system.

Reason for Change

The Committee is concerned that the Medicare Advantage (MA) risk adjustment system does not adequately account for a variety of factors, such as costs associated with low income and chronic conditions, and that multiple years of beneficiary data and further gradations of disease are not included in the system yet could improve the system's accuracy. This evaluation will allow the Secretary to determine if, accounting for these factors, the risk adjustment system can be improved to better project enrollees' costs.

Effective Date

Date of enactment.

Sec. 1168. Elimination of the MA Regional Plan Stabilization Fund

Current Law

MMA created the MA Regional Program and established the MA Regional Plan Stabilization Fund to encourage plans to enter into and/or remain in the MA Regional Program. The fund was originally set at $10 billion with additional money added to the fund from savings in the bidding process. Funds were to be available from 2007 through the end of 2013. Subsequent legislation decreased the amount of funds available and delayed their availability. Most recently, MIPPA reduced the initial funding of the program to one dollar. Money from the regional plan bidding process continues to flow into the Fund. Expenditures from the Fund are delayed until 2014.

Proposed Law

The provision would eliminate the MA Regional Plan Stabilization Fund. Any amounts contained in the Fund would be transferred to the Federal Supplementary Medical Insurance Trust Fund.

Reason for Change

Regional PPOs are no longer a new plan type and the Medicare Advantage program is a relatively stable market. This fund is not necessary.

Effective Date

Date of enactment.

Part 2—Consumer Protections and Anti-Fraud

Sec. 1171. Limitation on Out-of-pocket Costs for Individual Health Services

Current Law

Each MA plan must provide all required Part A and B Medicare benefits (other than hospice) to individuals entitled to Medicare Part A and enrolled in Part B. The aggregate amount of cost sharing in a MA plan must be equal to the aggregate amount of cost sharing in traditional Medicare. Cost sharing per enrollee (excluding premiums) for covered services cannot be more than the actuarial value of the deductibles, coinsurance, and co-payments under traditional Medicare. Dual eligibles are persons also entitled to the full range of benefits under their state's Medicaid program. Qualified Medicare beneficiaries (QMBs) are those aged or disabled individuals that are entitled to have some of their Medicare cost sharing and Part B premiums paid by the federal-state Medicaid program, but are not entitled to coverage of Medicaid plan services.

Proposed Law

For plan years beginning on or after January 1, 2011, MA plans would be prohibited from offering benefits with cost sharing requirements that are greater than the cost sharing requirements imposed under the traditional Medicare program. The "actuarially equivalent" standard in the statute would be eliminated. Medicare private plans would not be prohibited from using flat co-payments

or per diem rates in lieu of the cost sharing amounts imposed under Part A and B Medicare, as long as they did not exceed the level of cost sharing under traditional Medicare. This provision would also prohibit plans from imposing cost-sharing for dual-eligible individuals or qualified Medicare beneficiaries enrolled in an MA plan that exceeds the cost-sharing amounts permitted under the Medicare and Medicaid statutes.

Reason for Change

Using a standard of actuarial equivalence across cost sharing for all services leaves an opportunity for MA plans to increase cost sharing for infrequently-used services that enrollees may not scrutinize—like home health or cancer drugs—while lowering cost sharing for more commonly used services, like physician visits. While this may be attractive for enrollees who are relatively healthy, it has potentially devastating out-of-pocket cost implications for those enrollees who fall sick. MA plans that receive a rebate, because their bid is below the county benchmark, can use this rebate to lower cost sharing for certain services, either to attract enrollment or to encourage use of certain services (e.g. visits to a primary care physician). Setting a maximum cost sharing that does not exceed cost sharing under traditional Medicare ensures that no beneficiary will have higher out-of-pocket costs just because they choose to receive Medicare services through a private plan.

Effective Date

January 1, 2011.

Sec. 1172. Continuous Open Enrollment for Enrollees in Plans with Enrollment Suspension

Current Law

Special Election Periods (SEPs) allow beneficiaries the option to discontinue their enrollment in a MA plan and enroll in a different MA plan or traditional Medicare outside of the annual coordinated election period. The circumstances in which an enrollee can exercise this option include (1) an MA plan terminates its participation in the MA program or in a specific area, (2) an individual's place of residence changes, (3) the MA plan violates a provision of its contract or misrepresents the plan's provisions in marketing the plan, or (4) other exceptional conditions as provided by the Secretary.

Proposed Law

This provision would require the Secretary to take into account the health or well-being of an individual when determining what constitutes eligibility for a SEP. This provision would expand the categories of beneficiaries eligible to participate in a SEP to include beneficiaries enrolled in private plans that have been suspended for not meeting the terms of their contract.

Reason for Change

The Secretary has authority to suspend enrollment in MA plans that are not in compliance with various program requirements. The Committee believes that if an MA plan's behavior is egregious

enough that the Secretary would prohibit new enrollees, the current enrollees should be allowed an opportunity to disenroll, either for another MA plan or to traditional Medicare. Furthermore, the Secretary has wide latitude to establish additional SEPs, and the Committee believes that the Secretary should consider the health and well-being of beneficiaries when establishing these SEPs.

Effective Date

Date of enactment.

Sec. 1173. Information for Beneficiaries on MA Plan Administrative Costs

Current Law

The Secretary must provide for activities to disseminate information to current and prospective Medicare beneficiaries about MA plans, including, but not limited to benefits, cost sharing, service area, access, out-of-area coverage, emergency coverage, and supplemental benefits.

By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages.

Proposed Law

This provision would require the publication of administrative cost information, including the medical loss ratio (MLR), for MA plans. Plans that fail to meet a minimum MLR would be subject to sanctions, such as enrollment suspension and potential termination.

Beginning in 2011, the Secretary would be required to publish the MLR for the previous year by November 1st for each MA plan contract. MLRs would be defined by the Secretary, taking into account the definition adopted by the Health Choices Commissioner under section 116 of this Act. Each MA plan would be required to submit to the Secretary, in a manner and form specified by the Secretary, the necessary data for publishing MLR information on a timely basis. For 2010 and 2011, the data submitted would be required to be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

For contract years beginning in 2010, the Secretary would be required to develop and implement standardized elements and definitions for reporting the data necessary to calculate a MLR. The elements and definitions would be developed in consultation with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners. The Secretary would be required to publish a report describing the elements and definitions no later than December 31, 2010.

Beginning in 2014, if the Secretary determines that a MA plan failed to have a MLR of at least 0.85, the Secretary would be required to mandate that the MA plan provide enrollees with a rebate of their Part C premiums (or Part B or D, if applicable) by the amount necessary to meet a MLR of at least 0.85. The Secretary would also be required to restrict enrollment in the MA plan for 3 consecutive years and terminate the plan's contract if the plan failed to meet the MLR requirements for 5 consecutive years.

Reason for Change

Medicare Advantage plans claim to provide significant extra benefits, but neither the plans nor CMS quantify whether any of the revenue plans receive from the government is actually spent on enhanced benefits. According to MedPAC, MA plans on average currently spend more than 13 percent of their Medicare payments on administrative costs and profits.

The Medical Loss Ratio is the percentage of health plan revenue actually spent on direct patient care versus profit and administrative overhead. In the annual MA bidding process, plans report data on administrative costs and the other factors necessary for the calculation of a Medical Loss Ratio. Though currently unavailable, disclosure of these ratios will help beneficiaries choose efficient plans and will help the Congress make future program improvements.

MA plans should provide care in an efficient manner. This section provides for a minimum MLR of 0.85 for MA plans beginning in 2014 so that beneficiaries and taxpayers would not pay more than 15 cents per dollar for administrative costs and profits. The Health Choices Commissioner will enact standards for minimum MLRs for qualifying plans in the Health Insurance Exchange.

Effective Date

Date of enactment.

Sec. 1174. Strengthening Audit Authority

Current Law

The Secretary is required to provide for the annual auditing of the financial records of at least ⅓ of MA plans. Each contract with an MA plan is required to provide that the Secretary has the right to inspect or evaluate the quality, appropriateness and timeliness of services performed under the contract. Contracts must also provide the Secretary with the right to audit any plan's books and records related to the plan's ability to bear risk, the services delivered, or any amounts payable under the contract.

Proposed Law

Each contract with an MA plan would be required to include a provision that the Secretary have the authority to take necessary action, including the pursuit of financial recoveries, to address deficiencies identified during an annual audit. The provision would apply to Part D Prescription Drug Plans (PDPs) in the same manner as certain other MA contract provisions apply to PDP plans. The provision would apply to audits conducted for contract years beginning on or after January 1, 2011.

Reason for Change

The Committee believes that if the Secretary identifies deficiencies in MA plans or PDPs, the Secretary should have the authority to act to remedy those deficiencies.

Effective Date

January 1, 2011.

Sec. 1175. Authority to Deny Plan Bids

Current Law

By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages.

Potential PDP sponsors are also required to submit bids by the first Monday in June of the year prior to the plan benefit year. The following information must be included with the bid: (1) coverage to be provided; (2) actuarial value of qualified prescription drug coverage in the region for a beneficiary with a national average risk profile; (3) information on the bid, including the basis for the actuarial value, the portion of the bid attributable to basic coverage and, if applicable, the portion attributable to enhanced coverage, and assumptions regarding the reinsurance subsidy; and (4) service area. The bid also includes costs (including administrative costs and return on investment/profit) for which the plan is responsible. The bid must exclude costs paid by enrollees, payments expected to be made by CMS for reinsurance, and any other costs for which the sponsor is not responsible.

Proposed Law

Beginning January 1, 2011, the Secretary would not be required to accept any or every bid submitted by an MA or PDP plan.

Reason for Change

Under current law, the Secretary has the authority to negotiate bids with most MA plans and PDPs. The Committee believes that this negotiation process can be an important part of the annual bid process, however the Committee also believes that the Secretary should have explicit authority to reject bids from plans with which it cannot negotiate satisfactorily, or for other reasons. The Secretary should hold private plans wishing to provide care to Medicare beneficiaries to a high standard and should be permitted to exclude plans that do not meet that standard.

Effective Date

January 1, 2011.

Part 3—Treatment of Special Needs Plans

Sec. 1176. Limitation on Enrollment Outside Open Enrollment Period of Individuals into Chronic Care Specialized MA plans for Special Needs Individuals

Current Law

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173), Congress created a new type of Medicare Advantage (MA) coordinated care plan focused on individuals with special needs. Special Needs Plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals identified by Congress as 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

The number of SNPs has increased dramatically since 2004, the first year of operation. In 2004, CMS approved 11 SNPs, but by January 2008, CMS had approved 787 SNPs, including 442 dual-eligible SNPs, 256 chronic care SNPs, and 89 institutional SNPs. In September 2008, there were 1.2 million beneficiaries in SNPs.

Under current law, Medicare beneficiaries may enroll in or change their enrollment in MA plans from November 15th to December 31st each year. Changes go into effect January 1st of the next year. During the first three months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. Beneficiaries may also enroll in MA or switch their enrollment if they qualify for a Special Election Period (SEP) as defined in statute or by the Secretary. One SEP specified by the Secretary in the *Medicare Managed Care Manual* allows individuals with severe or disabling chronic conditions to enroll in an SNP designed for individuals with those conditions. This SEP applies as long as the individual has the qualifying condition and ends once the beneficiary enrolls in an SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods.

Proposed Law

This provision would require that beginning on January 1, 2011, SNPs serving beneficiaries with severe or disabling conditions could only enroll eligible individuals during an annual, coordinated open enrollment period or at the time of diagnosis of the disease or condition that would qualify an individual for a chronic care SNP.

Reason for Change

The Committee is concerned that the current SEP for beneficiaries eligible for a chronic condition SNP encourages aggressive marketing by plans and is confusing for beneficiaries accustomed to annual enrollment periods. The new SEP must be more narrowly targeted to the time around a beneficiary's diagnosis, but the Committee gives authority to the Secretary to determine how long after a diagnosis the beneficiary is permitted to elect an SNP. The Committee intends that this be a length of time sufficient for the bene-

ficiary to understand the consequences of a diagnosis and learn about options for specialized plans.

Effective Date

January 1, 2011.

Sec. 1177. Extension of Authority of Special Needs Plans to Restrict Enrollment

Current Law

Prior to January 1, 2011, SNPs may restrict enrollment to those who are in one or more classes of special needs individuals. Starting January 1, 2010, new SNP enrollment must be limited exclusively to individuals that meet the criteria for which the SNP is designated: dual eligible, chronic care, and institutional care. Further, MIPPA required that dual eligible SNPs contract with state Medicaid agencies to provide medical assistance services (Medicaid), which may include long-term care services. If SNPs do not have contracts with Medicaid agencies by January 1, 2010, then they can continue to operate, but are prohibited from expanding their service areas. However, state Medicaid agencies are not required to enter into contracts with SNPs.

Proposed Law

This provision would extend the time period, from January 1, 2011, to January 1, 2013, during which SNPs may restrict current enrollment to individuals who meet the definition of the respective SNP. In addition, selected SNPs that had contracts with states that had a state program to operate an integrated Medicaid-Medicare program that was approved by CMS as of January 1, 2004, would be allowed to restrict enrollment to beneficiaries who meet the definition of special needs individuals through January 1, 2016.

Through a contract with an independent health services evaluation organization, the Secretary would be required to provide an analysis of the SNPs that were approved by CMS as of January 1, 2004. The analysis of these grandfathered SNPs would include the impact of such plans on cost, quality of care, patient satisfaction, and other subjects as specified by the Secretary. By December 31, 2011, the Secretary would be required to submit a report to Congress on the analysis of the grandfathered SNPs, which would include recommendations on the appropriate treatment of these plans.

Reason for Change

Congress and the Secretary have taken legislative and regulatory steps to ensure that SNPs truly offer specialized services for the populations enrolled. The Committee believes that SNP authority should be extended for a limited number of years in order to allow plans to meet these requirements.

A small subset of SNPs that have fully integrated Medicare and Medicaid services for dually eligible beneficiaries would receive a longer extension, as these plans have demonstrated an ability to integrate care, as originally envisioned for the SNP program.

Effective Date

Date of enactment.

Subtitle E—Improvements to Medicare Part D

Sec. 1181. Elimination of Coverage Gap

Current Law

Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit. In 2009, the standard benefit includes a $295 deductible and a 25% coinsurance until the enrollee reaches $2,700 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, $6,153.75 in 2009. Each year, the deductible, co-payments, and coverage thresholds are increased by the annual percentage increase in average per-capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.

Part D plan sponsors are allowed to offer plans that differ in benefit design, but are actuarially equivalent, or they may offer "enhanced" plans that offer more generous coverage. Currently, almost all plans include a coverage gap in their benefit designs. CMS estimates that 31.7% (8.3 million) Part D enrollees reached the initial coverage limit of their drug plans in 2007.

Some beneficiaries with limited income and resources may qualify for assistance with a portion of their Part D premiums, cost-sharing, and other out-of-pocket expenses. Medicare beneficiaries who qualify for Medicaid based on their income and assets (dual eligibles) are automatically deemed eligible for the full low-income subsidy. Prior to the implementation of the Medicare Part D outpatient prescription drug benefit, established by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, P.L. 108–173), Medicaid was the primary payer for drugs for full-benefit dual-eligible beneficiaries.

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) requires drug manufacturers who wish to have their drugs available for Medicaid enrollees to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under the agreements, pharmaceutical manufacturers must provide state Medicaid programs with rebates on drugs paid for Medicaid beneficiaries. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. In return for entering into agreements with the Secretary, state Medicaid programs are required to cover all of the drugs marketed by those manufacturers (with possible exceptions for the 11 categories of drugs that states are allowed to exclude from coverage).

The rebates are computed and remitted by pharmaceutical manufacturers each quarter based on utilization information supplied by the state programs. States collect the rebates from the manufacturers. The federal share of the rebates are subtracted from states' claims for their federal share of program costs. In setting the amount of required rebates, the law distinguishes between two

classes of drugs. The first includes single source drugs (generally, those still under patent) and "innovator" multiple source drugs (drugs originally marketed under a patent or original new drug application (NDA) but for which generic competition now exists). The second class includes all other, "non-innovator" multiple source drugs (generics).

Manufacturers are required to pay state Medicaid programs a basic rebate for single source and innovator multiple source drugs. Basic rebate amounts are determined by comparing the Average Manufacturer Price (AMP) for a drug to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public entity. Under current law, the basic rebate is the greater of 15.1% of the AMP or the difference between the AMP and the best price. For non-innovator multiple source drugs, basic rebates are equal to 11% of the AMP. Manufacturers are also required to pay an additional Medicaid inflation rebate for single source drugs. This rebate is equal to the amount by which the increase in the AMP of the single source drug exceeds the increase in the consumer price index.

Proposed Law

Coverage Gap

This provision would phase in an elimination of the coverage gap. For each year beginning with 2011, the Secretary would progressively increase the initial coverage limit and decrease the annual out-of-pocket threshold until there is a continuation of coverage from the initial coverage limit up to the expenditure threshold at which catastrophic coverage begins. Starting in 2011, the initial coverage limit for each year, as determined using current annual percentage increase methodology, would be increased by Y2 of the cumulative phase-in percentage (the sum of the annual phase-in percentage for the year and the annual phase-in percentages for each previous year) times the out-of-pocket gap amount (the amount by which the annual out-of-pocket threshold for the year exceeds the sum of the annual deductible for the year and ¼ the amount by which the initial coverage limit for the year exceeds the annual deductible). Also beginning in 2011, the annual out-of-pocket threshold would be decreased by ½ of the cumulative phase-in percentage of the out-of pocket gap amount for the year multiplied by 1.75.

The annual phase in percentage would be 13% for 2011; 5% for years 2012 through 2015; 7.5% for years 2016 through 2018, and 10% for 2019 and each subsequent year.

Requiring Drug Manufacturers to Provide Rebates for Full-Benefit Dual Eligibles

Under this provision, drug manufacturers would be required to provide the Secretary a rebate for any covered Part D drug of the manufacturer dispensed after December 31, 2010 to any full-benefit dual eligible individual for which payment was made by a prescription drug plan (PDP) sponsor or a Medicare Advantage (MA) organization.

The amount of the rebate for a rebate period would be equal to the product of the total number of units of such dosage form and

strength of the drug dispensed and the amount, if any, by which the Medicaid rebate, as modified by this statute, and including both the basic and inflation rebate, for such form, strength, and period, exceeds the average Medicare drug program full-benefit dual eligible rebate amount for such form, strength, and period.

The average Medicare drug program full-benefit dual eligible rebate amount means, with respect to each dosage form and strength of a covered outpatient drug provided by a manufacturer for a rebate period, the sum for all PDP sponsors and MA organizations administering a Medicare Advantage drug plan (MA–PD), of the product for each such sponsor or organization of: the sum of all rebates, discounts, or other price concessions, calculated on a per unit basis (but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to full-benefit dual eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not full-benefit dual eligible enrollees), and the number of units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible enrollees, divided by the total number of units of the drug dispensed during the rebate period to all full-benefit dual eligible PDP and MA–PD enrollees.

In general, a rebate agreement would be effective for an initial period of not less than 1 year and would be automatically renewed for a period of not less than 1 year. The Secretary would be required to establish other terms and conditions of the rebate agreement including terms and conditions related to compliance.

For contract years beginning on or after January 1, 2011, each drug plan contract entered into with a PDP sponsor or a MA organization would require that the sponsor or organization report to each manufacturer not later than 60 days after the end of each rebate period, information on the total number of units of each dosage, form, and strength of each drug the manufacturer dispensed to full-benefit dual eligible Medicare drug plan enrollees under any PDPs or MA–PDs operated by the sponsor during the rebate period; information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period; information on the extent to which such price discounts, price concessions, and rebates apply equally to full-benefit dual eligible Medicare drug plan enrollees and enrollees who are not full-benefit dual eligible plan enrollees; and any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program full-benefit dual eligible rebate amount. The report would be in a form consistent with a standard reporting format established by the Secretary, and a copy of the information would be reported to the Secretary for the purpose of oversight and evaluation. The information submitted would be treated as confidential. The rebate would be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of this information.

The provision would allow the Medicare Payment Advisory Commission, the Congressional Budget Office and the GAO access to the information, and the information reported may be used by the HHS Office of Inspector general for audits, investigations, and evaluations. Additional confidentiality provisions (with the exception of clause iv) from the Medicaid rebate section (1927(b)(3)) of

the Social Security Act also apply to the Medicare Part D rebate data reported under this section.

In cases where information was not submitted timely or if false information is submitted, penalties would be imposed. PDP sponsors and MA organizations would be subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided. If the sponsor or organization knowingly provides false information, the sponsor or organization would be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such penalties would be in addition to any other civil money penalties as may be prescribed by law.

The rebates for full-benefit dual eligible Medicare drug plan enrollees would be paid into the Medicare Prescription Drug Account in the Supplementary Medical Insurance Trust Fund and used to pay for all or part of the gradual elimination of the coverage gap.

Reason for Change

When prescription drug coverage for six million dually eligible beneficiaries was switched from Medicaid to Medicare Part D in 2006, drug manufacturers received a windfall amounting to almost $4 billion in just the first two years of the program. While Medicaid rebates are statutorily required at a certain level, rebates in the Part D program are entirely negotiated between plans and manufacturers, giving the federal government and taxpayers who pay for the Part D program—no control over the level of rebate provided. Requiring that rebates from drug manufacturers in the Part D program match the rebates required under Medicaid ensures that for the same beneficiary, manufacturers are not permitted to charge higher prices to the government under Part D than under Medicaid. Manufacturers will continue to enter into rebate agreements with the Part D plans, however, if that rebate amount does not equal the Medicaid rebate amount for a particular drug, the manufacturer would be required to make up the difference in rebate payments directly to the federal government. With respect to GAO, the confidentiality provision that incorporates section 1927(b)(3) of the Social Security Act is intended to reflect and confirm GAO's existing right to access Part D information in light of its broad authority at 31 U.S.C. 716.

Funds received from the new rebate requirement will be used to pay for, in whole or in part, the elimination of the Part D coverage gap. Since the program's inception, this mid-year gap in benefits has plagued millions of beneficiaries who continue to pay their monthly premium, yet also have to pay 100 percent of the cost of their drugs out-of-pocket. This section would eliminate the gap over time, ensuring that beneficiaries are insured against the full cost of drugs throughout the entire benefit year.

Effective Date

January 1, 2011.

Sec. 1182. Discounts for Certain Part D Drugs in Original Coverage Gap

Current Law

No provision.

Proposed Law

Manufacturers of prescription drugs would, as a condition of allowing any of the drugs they manufacture to be treated as covered drugs under Medicare Part D, be required to enter into agreements with Medicare Part D drug plan sponsors to provide discounts on covered Part D drugs provided to plan enrollees in the coverage gap period. This provision would be applicable to drugs dispensed after December 31, 2010.

Under a discount agreement, a drug manufacturer would be required to provide to each PDP or MA–PD plan a discount for qualifying drugs of the manufacturer dispensed to a qualifying enrollee when in the original Part D coverage gap. A qualifying drug would be defined as drug that is produced under an original new drug application approved by the FDA, or a drug that was initially marketed under such an application, or a biological product approved under Section 351(a) of the Public Health Service Act, and that is covered under the plan's formulary and is dispensed to an individual who is in the original coverage gap.

The Secretary would establish the terms and conditions of the discount agreement, including those relating to compliance, similar to the terms and conditions for rebate agreements between states and drug manufacturers for drugs provided to Medicaid recipients. However, the discounts would be applied to PDPs and MA-PD plans rather than to states; PDP sponsors and MA organizations, instead of states, would be required to provide the necessary utilization information to drug manufacturers; and PDP sponsors and MA organizations would be responsible for reporting information on drug-component negotiated prices instead of other manufacturer prices used in calculating Medicaid rebates.

The amount of the discount for a discount period for a plan would be equal to 50 percent of the amount of the negotiated price for qualifying drugs, excluding any dispensing fee for the period involved. The sponsor or plan would provide the discount to the enrollee at the time the enrollee pays for the drug if the enrollee is in the actual gap in coverage, and in such cases the amount of the discount, in addition to the amount actually paid by the enrollee, would count toward costs incurred by the plan enrollee. If the enrollee is in the portion of the original gap in coverage that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price for the purpose of calculating the beneficiary payment.

A qualifying enrollee is defined as an individual who is enrolled in a PDP or an MA-PD plan who is not a subsidy-eligible individual as defined in section 1860–D–14(a)(3). The original gap in coverage is defined as the gap that would occur between the initial coverage limit and the out-of-pocket threshold if the phase-out of the coverage gap described in Section 1181 did not apply. The actual gap in coverage refers to the gap between the initial coverage limit and the out-of-pocket threshold as modified by Section 1181.

With regard to payments to pharmacists, discounts under this section are to be treated in a similar fashion to any other discounts, rebates, or price concessions provided to PDP sponsors, and payments to pharmacists in conjunction with these discounts are to be made consistent with prompt payment requirements under Section 1860D–12(b)(4), with the pharmacist to be fully reimbursed for clean claims within 14 days.

Reason for Change

In June 2009, the trade association representing brand-name pharmaceutical manufacturers—PhRMA—pledged to provide a 50 percent discount to seniors in the Part D coverage gap to alleviate the high costs that seniors currently faced. This section would enact that promise into law. All Medicare beneficiaries who would otherwise face 100 percent cost sharing in the coverage gap, would receive a 50 percent discount on brand-name drugs. While this discount is important and will provide immediate relief for millions of seniors, it will still leave many beneficiaries with high out-of-pocket costs in the gap. Simultaneously, the act gradually closes the coverage gap so seniors' drug costs will be more consistent throughout the benefit year.

Effective Date

January 1, 2011.

Sec. 1183. Repeal of Provision Relating To Submission of Claims by Pharmacies Located in or Contracting With Long-Term Care Facilities

Current Law

Section 172 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110–275) provided for a new set of requirements for contracts between Part D drug plan sponsors and pharmacies located in or contracting with long-term care facilities for plan years beginning on or after January 1, 2010. Under this section, each contract entered into with a PDP sponsor or MA-PD plan is required to provide that a pharmacy located in or having a contract with a longterm care facility would have between 30 and 90 days to submit claims for reimbursement.

Proposed Law

Section 172 of MIPPA would be repealed. This provision would be applicable for contract years beginning with 2010.

Reason for Change

This provision is repealed to allow long-term pharmacies and nursing homes more time to coordinate with state Medicaid programs.

Effective Date

January 1, 2010.

Sec. 1184. Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs Toward the Annual Out of Pocket Threshold Under Part D

Current Law

Under a standard Medicare Part D plan design, beneficiaries must incur a certain level of out-of-pocket costs ($4,350 in 2009) before catastrophic protection begins. These include costs that are incurred for the deductible, cost-sharing, or benefits not paid because they fall in the coverage gap. Costs are counted as incurred, and thus treated as true out-of-pocket (TrOOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or paid under a State Pharmaceutical Assistance Program. Incurred costs do not include amounts for which no benefits are provided—for example, because a drug is excluded under a particular plan's formulary. Additional payments that do not count toward TrOOP include Part D premiums and coverage by other insurance, including group health plans, workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties.

Proposed Law

The provision would treat as incurred those costs that are borne or paid by the Indian Health Service, Indian tribe or tribal organization or an urban Indian organization (as defined in Section 4 of the Indian Health Care Improvement Act) to count toward the out-of-pocket threshold. Costs paid under an AIDS Drug Assistance Program under Part B of Title XXVI of the Public Health Service Act would also count toward the out-of-pocket threshold. The provision would apply costs incurred on or after January 1, 2011.

Reason for Change

This requires the Secretary to count contributions from other programs designed to help beneficiaries with their drug costs for the purpose of a beneficiary reaching the catastrophic cap.

This change will lower costs for beneficiaries who receive assistance from other sources from continuing to paying higher costs for prescription drugs.

Effective Date

January 1, 2011.

Sec. 1185. Permitting Mid-Year Changes in Enrollment for Formulary Changes That Adversely Impact an Enrollee

Current Law

Part D plans are permitted to operate formularies—lists of drugs that a plan chooses to cover and the terms under which they are covered. By law, Part D plans may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit, to take into account new therapeutic uses and newly-approved covered Part D drugs. The law further stipulates that any removal of a covered

Part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

Under current regulations, a Part D sponsor may not remove a covered Part D drug from its Part D plan's formulary or make any change in the preferred or tiered cost-sharing status of a covered Part D drug on its plan's formulary between the beginning of the open enrollment period and 60 days after the beginning of the contract year associated with that open enrollment period except under certain circumstances, for example, when a covered drug has been deemed unsafe by the FDA or removed from the market by its manufacturer. After March 1 of a given plan year, Part D sponsors may make maintenance changes to their formularies, such as replacing brand name drugs with new generic drugs or modifying formularies as a result of new information on drug safety or effectiveness. According to CMS policy, if Part D sponsors remove Part D drugs for their formularies, move covered Part D drugs to a less preferred tier status, or add utilization management requirements, these changes must be approved by CMS and sponsors may make such changes only if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the contract year.

Part D sponsors may expand formularies by adding drugs to their formularies, reducing copayments or coinsurance by placing a drug on a lower cost-sharing tier, or deleting utilization management requirements at any time during the year.

Proposed Law

The provision would establish a special open enrollment period for an individual to change plans during a period other than during the annual open enrollment period. The provision would apply to an individual enrolled in a prescription drug plan (or an MA-PD plan) who has been prescribed and is using a drug while enrolled in the plan in the case where the formulary of the plan materially changed (other than at the end of the contract year) such as to reduce coverage or increase the cost-sharing of the drug. The provision would not apply in cases where the drug was removed from the formulary because of a recall or withdrawal issued by the Food and Drug Administration or because the drug was replaced with a therapeutically equivalent generic drug. The provision would also not apply in instances where utilization management was applied for drugs for which FDA required a boxed warning or drugs subject to a Risk Evaluation and Management Strategy under subsection (f) of Section 505–1 of the Federal Food, Drug, and Cosmetic Act. The provision would apply to contract years beginning on or after January 1, 2011.

Reason for Change

Beneficiaries choose prescription drug plans based on a number of factors, not the least of which is whether a plan covers the drugs they are currently taking. Though CMS has imposed certain restrictions on plan formulary changes, there is no protection for beneficiaries who are nonetheless harmed by a mid-year formulary change. This provision will allow adversely affected beneficiaries to

choose a new plan, and will discourage plans from making mid-year formulary changes for highly prescribed drugs.

Effective Date

January 1, 2011.

Subtitle F—Medicare Rural Access Protections

Sec. 1191. Telehealth Expansion and Enhancements

Current Law

Medicare covers certain services including professional consultations, office and other outpatient visits, individual psychotherapy, pharmacological management, psychiatric diagnostic interview examinations, neurobehavioral status exams, and end stage renal disease related services delivered via an eligible telecommunications system. An interactive telecommunications system is required as a condition of payment. The originating site (the location of the beneficiary receiving the telehealth service) can be a physician or practitioner's office, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital-based renal dialysis center, a skilled nursing facility, a community mental health center or a hospital. The originating site must be in a rural health professional shortage area or in a county that is not in a metropolitan statistical area or at an entity that participates in a specified federal telemedicine demonstration project.

Proposed Law

A renal dialysis facility would be included as a covered originating site for telehealth services effective for services starting January 1, 2011.

The Secretary would appoint a Telehealth Advisory Committee to make policy recommendations concerning/regarding telehealth services including the appropriate addition or deletion of covered services and procedure codes for authorized payments.

The Advisory Committee would be composed of 9 members: 5 would be practicing physicians; 2 would be practicing nonphysician health care practitioners, and 2 shall be administrators of telehealth programs. In appointing the committee members, the Secretary would be required to ensure that each member has prior experience with the practice of telemedicine or telehealth; would give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs; would ensure that committee membership represents a balance of specialties and geographic regions; and would take into account the recommendations of stakeholders.

The Telehealth Advisory Committee would meet at least twice each calendar year and at other times provided by the Secretary. The committee members would serve for the term specified by the Secretary. An advisory committee member would not be able to participate in a particular matter considered in meeting if such a member (or an immediate family member) had a financial interest that could be affected by the advice given to the Secretary. Section 14 of the Federal Advisory Committee Act governing termination, renewal and continuation of committees would not apply. The Secretary would establish this committee regardless of any limitation

that would apply to the number of advisory committees that may be established with the Department of Health and Human Services or otherwise.

In making determinations with respect to covered services, the Secretary would be required to take into account the recommendations of the Telehealth Advisory Committee. If the Secretary does not implement a recommendation, the Secretary would publish a statement providing the reason for such decision in the Federal Register.

A telemedicine practitioner that is credentialed by a hospital in compliance with the Joint Commission Standards for Telemedicine would be considered in compliance with conditions of participation and reimbursement credentialing requirements for Medicare.

Reason for Change

Telehealth services can be a valuable way of delivering high quality care to underserved and other areas. This provision expands Medicare's telehealth benefit and ensures that CMS receives valuable outside expertise in the administration of the benefit.

Effective Date

January 1, 2011 for services provided by renal dialysis facilities; date of enactment for all other provisions.

Sec. 1192. Extension of Outpatient Hold Harmless Provision

Current Law

Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals received 95% of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals receive 90% of the difference in CY2007 and 85% of the difference in CY2008 and CY2009. Sole community hospitals with not more than 100 beds receive 85% of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010.

Proposed Law

Small rural hospitals and sole community hospitals with not more than 100 beds would receive 85% of the payment difference for covered HOPD services furnished until January 1, 2012.

Reason for Change

This provision protects small rural hospitals from the financial losses they would face under the outpatient prospective payment system. Eligible hospitals will receive a partial hold harmless payment until the end of CY2011.

Effective Date

January 1, 2010.

Sec. 1193. Extension of Section 508 Hospital Reclassifications

Current Law

Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108–173) provided $900 million for a one-time, 3-year geographic reclassification of certain hospitals that were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006 (P.L. 109–432). The Medicare, Medicaid and SCHIP Extension Act (P.L. 110–173) extended the reclassifications to September 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) extended the reclassifications until September 30, 2009. These extensions are exempt from any budget neutrality requirements.

Proposed Law

The Section 508 reclassifications would be extended until September 30, 2011.

Reason for Change

This provision extends the MMA Section 508 geographic reclassification designations, and allows for other geographic reclassification designations, so that these hospitals may better compete with neighboring hospitals. The Committee notes that there are some hospitals that are eligible for reclassification both under the Medicare Geographic Classification Review Board (MGCRB) process as set forth at Section 1886(d)(10) of the Social Security Act and under Section 508. When publication of the final regulation for the Medicare inpatient prospective payment system precedes enactment of a Section 508 extension, these hospitals' wages are included into the reclassified wage index of the area to which they are being reclassified. The Committee does not see the need to provide further adjustments to these hospitals as the reclassified wage index they receive in such a scenario reflects inclusion of their own wages.

Effective Date

October 1, 2010.

Sec. 1194. Extension of Geographic Floor for Work

Current Law

The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices that reflect how each area compares to the national average in a "market basket" of goods. A geographic practice cost index (GPCI) with a value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December 2009. The

other geographic indices (for practice expense and medical malpractice) were not modified by these Acts.

Proposed Law

The proposal would extend the 1.00 floor for the geographic index for physician work for an additional 2 years through December 2011.

Reason for Change

Rural physicians put in as much time, skill, and intensity into their work as physicians in urban areas. This provision ensures that rural physicians are paid at least the average rate for their work.

Effective Date

January 1, 2010.

Sec. 1195. Extension of Payment for Technical Component of Certain Physician Pathology Services

Current Law

Legislation enacted in 1997 specified that independent labs that had agreements with hospitals on July 22, 1999 to bill directly for the technical component of pathology services could continue to do so in 2001 and 2002. The provision has been periodically extended, most recently through December 31, 2009 by MIPPA.

Proposed Law

The bill would extend this provision through 2011.

Reason for Change

This provision is needed in order to continue allowing direct billing for the technical component for independent labs that have agreements with hospitals. Without this extension, hospitals will incur an additional cost that is not included in the payment rate under the prospective payment system. This provision protects rural beneficiaries' access to laboratory services.

Effective Date

January 1, 2010.

Sec. 1196. Extension of Ambulance Add-Ons

Current Law

Ambulance services are paid on the basis of a national fee schedule, which is being phased in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The national fee schedule is fully phased in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007–2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.

The fee schedule payment for an ambulance service equals a base rate for the level of service plus payment for mileage. Geographic

adjustments are made to a portion of the base rate. For the period July 2004 to December 2009, mileage payments are increased for ground ambulance services originating in rural low population density areas. For the period July 1, 2004 until December 31, 2008, there is a 25% bonus on the mileage rate for trips of 51 miles and more. Payments for ground transports originating in rural areas or rural census tracts are increased by 3% for the period of October 1, 2008 through December 31, 2009.

MIPPA specifies that any area designated as rural for the purposes of making payments for air ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008 until December 31, 2009.

Proposed Law

The provision would maintain the 3% higher payments for ground transports originating in rural areas or rural census tracts until December 31, 2011. The MIPPA provision maintaining the designation of certain areas as rural for the purposes of Medicare's payments for air ambulance services would be maintained until December 31, 2011.

Reason for Change

This provision helps to cover the cost of providing ambulance services in rural areas.

Effective Date

January 1, 2010.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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

Sec. 1201. Improving Assets Tests for Medicare Savings Program and Low-income Subsidy Program

Current Law

Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy, Medicare beneficiaries must have resources no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L.108–173, MMA).

Individuals may qualify for the full subsidy in two ways: 1) if they are eligible for Medicaid or one of the Medicare Savings Programs (Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI)), or are recipients of Supplemental Security Income (SSI) benefits, they are deemed automatically eligible; or 2) if they apply for the benefit, through their State Medicaid agency or through the Social Security Administration (SSA) and are determined to have an annual income below 135% of the federal poverty level (FPL) and have resources below a certain limit (in 2009, $6,600 for an individual or $9,910 if married). Beneficiaries may qualify for a partial subsidy if they apply and are determined to have an annual income

below 150% of the FPL and whose resources do not exceed a certain limit (in 2009, $11,010 for individuals or $22,010 if married). (When determining whether a beneficiary qualifies for the Medicare Part D low-income subsidy, $1,500 per person in resources are excluded from consideration if the beneficiary indicates that he/she expects to use resources for burial expenses; otherwise $1,500 should be added to the above asset limits for an individual and $3,000 for a couple.)

Proposed Law

Under this provision, the maximum resources levels used to determine eligibility for the low income subsidy would be increased. In 2012, the level would be $17,000 for an individual and $34,000 for a couple. In subsequent years, the asset level would be increased by the annual percent increase in the Consumer Price Index (all items, U.S. city average) as of September of the previous year.

These maximum resources levels would also apply for determining eligibility for Medicare Savings Programs, beginning January 1, 2012.

Reason for Change

Millions of low-income Medicare beneficiaries do not qualify for financial assistance under the Part D low-income subsidy (LIS) or the Medicare Savings Program (MSP) because they have a small nest egg that exceeds the maximum resource limits permitted by the programs. Even the presence of an asset test can be a barrier to applicants because of the daunting application process. This section harmonizes the asset tests for eligibility for all LIS eligible individuals—full and partial Part D subsidy—and the MSP to simplify the test, and raises the maximum level to prevent seniors with nest eggs from being disqualified from receiving the subsidy.

Effective Date

January 1, 2012.

Sec. 1202. Elimination of Part D) Cost-sharing for Certain Non-Institutionalized Full-Benefit Dual Eligible Individuals

Current Law

Cost-sharing subsidies for LIS enrollees are linked to the standard prescription drug coverage. Full-subsidy eligibles have no deductible, minimal cost sharing during the initial coverage period and coverage gap, and no cost-sharing over the catastrophic threshold.

Full-benefit dual eligibles who are residents of medical institutions or nursing facilities have no cost-sharing. Other full-benefit dual-eligible individuals with incomes up to 100% of poverty have cost-sharing, for all costs up to the out-of-pocket threshold, of $1.10 in 2009 for a generic drug prescription or preferred multiple source drug prescription and $3.20 in 2009 for any other drug prescription. All other full-subsidy-eligible individuals have cost-sharing for all costs up to the out-of-pocket threshold, of $2.40 in 2009 for a generic drug or preferred multiple source drug and $6.00 in 2009 for any other drug.

Proposed Law

Under this provision, cost-sharing would not apply to persons who were full benefit dual eligibles and for whom a determination was made that but for the provision of home and community based care, the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded and such care would be paid for by Medicaid. Such home and community based care would be that provided under Section 1915 or 1932 of the SSA or under a waiver under Section 1115 of the Act. The provision would apply to drugs dispensed on or after January 1, 2011.

Reason for Change

For decades, policymakers at the state and federal level have made efforts to eliminate the bias toward institutionalization for those needing long-term care services by providing benefits for needed health care services in community-based settings. Studies have shown that people needing long-term care prefer to receive benefits in the community and that often such benefits can be provided at less cost than similar benefits in an institution (e.g. a nursing home).

The Medicare Modernization Act, for purposes of the Part D benefit, distinguished between beneficiaries who receive care in a community setting and those in an institution. Beneficiaries in institutions were exempted from Part D cost sharing, but those in the community—who were equally poor and needed an equivalent level of care—were not. This provision in the Medicare drug bill was a setback to decades of federal and state policy to encourage, or at least be neutral toward, beneficiaries receiving care in home or community settings.

Extending the protection against cost-sharing to dually eligible beneficiaries who are eligible to be institutionalized in a hospital or facility for the mentally retarded ensures that these most vulnerable beneficiaries are not penalized for choosing to receive care in a home or community-based setting.

Effective Date

January 1, 2011.

Sec. 1203. Eliminating Barriers to Enrollment

Current Law

In general, federal law stipulates few documentation requirements for Medicaid applicants, including persons who apply for coverage under the Medicare Savings Program (MSP). Although states have flexibility to collect income and asset information through self-declaration alone, they also have the ability to require supporting documentation. State policies on this issue vary based on the eligibility group, but a considerable amount of documentation may be required to determine whether an individual meets financial eligibility requirements for Medicaid.

Under the Medicare Part D low-income subsidy program, full-benefit dual eligibles, those receiving assistance through Medicare Savings Programs, and recipients of SSI are deemed subsidy-eligible individuals for up to one year; other persons, or their personal

representatives, have to apply for assistance. Applicants may apply either at state Medicaid offices or Social Security offices. Applicants are required to provide information from financial institutions, as requested, to support information in the application, and to certify as to the accuracy of the information provided.

Proposed Law

Medicare beneficiaries applying for a low-income subsidy under the prescription drug program would be permitted to apply on the basis of self-certification of income and resources. The information provided would be subject to verification; however, and except in extraordinary situations as determined by the Commissioner of SSA, the individual would not be required to provide additional documentation. Verification would be accomplished through data-sharing between the SSA and the Internal Revenue Service described under existing authority. This provision would be effective beginning January 1, 2010.

Reason for Change

Administrative barriers often prevent low-income Medicare beneficiaries from accessing the Part D low-income subsidy (LIS) that they might be eligible for under the law. This section requires the Social Security Administration (SSA) to administratively verify a beneficiary's income and assets, without requiring submission of burdensome paperwork or financial documentation. SSA already has authority to verify eligibility for the LIS through data it obtains directly from the Internal Revenue Service without requiring seniors, many of whom are frail or have limited mobility, to present financial documents.

Effective Date

January 1, 2010.

Sec. 1204. Enhanced Oversight Relating to Reimbursements for Retroactive Low Income Subsidy Enrollment

Current Law

Certain groups of Medicare beneficiaries automatically qualify (and are deemed eligible) for the full low-income subsidy. Dual eligibles who qualify for Medicaid based on their income and assets are automatically deemed eligible for Medicare prescription drug low-income subsidies. Additionally, those who receive premium and/or cost-sharing assistance through the Medicare Savings Programs (MSP), plus those eligible for SSI cash assistance, are automatically deemed eligible for low-income subsidies and need not apply for them. CMS deems individuals automatically eligible for LIS effective as of the first day of the month that the individual attains the qualifying status (e.g., becomes eligible for Medicaid, MSP, or SSI). The end date is, at a minimum, through the end of the calendar year within which the individual becomes eligible.

These individuals' Medicaid prescription drug coverage ceases as soon as the individual is eligible for Part D, regardless of whether the individual is enrolled in a Part D plan. This creates the risk of gaps in coverage. To prevent gaps between the end of Medicaid prescription drug coverage and the start of Medicare prescription

drug coverage, CMS regulation specifies that auto-enrollment is effective the month in which the person becomes full-benefit dual eligible. Because Medicaid eligibility is often retroactive, CMS randomly auto-enrolls new full-benefit dual eligibles into Part D plans retroactive to the start of their full dual status.

Other individuals with limited income and resources who do not automatically qualify may apply for the low-income subsidy and have their eligibility determined by either the SSA or their state Medicaid agency. An individual who applies and is determined eligible for the LIS is eligible effective the first day of the month in which the individual submitted an application. In most cases, this means that LIS status is applied retroactively. If a beneficiary is already enrolled in a Part D plan, the Part D sponsor must take steps to ensure that the beneficiary has been reimbursed for any premiums or cost-sharing the member had paid that should have been covered by the subsidy.

The Centers for Medicare & Medicaid Services (CMS) issued a request for proposals (RFP) on February 17, 2009 to solicit a contractor (a national prescription drug plan sponsor) to cover Part D prescription drug claims for retroactive periods of coverage for full-benefit dual eligible and SSI-eligible individuals, as well as point-of-sale coverage at a pharmacy for certain individuals with the Part D low-income subsidy who are not yet enrolled in a Part D plan. Beginning in 2010, CMS has the demonstration authority to test a revised approach for providing retroactive and immediate need coverage. Under the demonstration, CMS will contract with a single PDP sponsor to pay for all claims for retroactive auto-enrollment periods plus current and immediate need claims for all LIS eligibles. CMS will modify its auto and facilitated enrollment process so that all those with retroactive effective dates are assigned to the demonstration for those retroactive periods, but continue to be randomly assigned for prospective periods to standard LIS PDPs.

Proposed Law

In the case of a retroactive LIS enrollment, the beneficiary, or a third party that is owed payment on behalf of the beneficiary, would be entitled to be reimbursed for covered drug costs incurred by the beneficiary during the retroactive coverage period. The retroactive coverage period is defined as the period beginning on the effective date of LIS assistance for which the individual is eligible and ending on the date the plan effectuates the status of such individual as eligible. Covered drug costs would be defined as the amount by which the costs incurred by the beneficiary for covered part D drugs, premiums and cost sharing exceeds such costs that would have been incurred if the beneficiary had been receiving a low-income subsidy to which the individual was entitled.

The reimbursement would be made automatically by the Part D plan sponsor upon appropriate notice that the beneficiary is eligible for assistance and no further information would need to be submitted to the plan by the beneficiary. For each such reimbursement, the PDP or MA-PD plan would be required to include a line-item description of the items for which the reimbursement is made. Additionally, the provision would require that reimbursement be submitted not later than 45 days after the date on which the plan receives notice from the Secretary that the beneficiary is eligible

for assistance or the date on which the beneficiary files the claim with the plan.

A retroactive LIS enrollment beneficiary would be defined as an individual who is enrolled in a PDP or an MA-PD plan and subsequently becomes eligible as a full-benefit dual eligible individual, Medicare Savings Program eligible, or eligible for SSI, or is a full-benefit dual eligible individual who is automatically enrolled in such a plan. Beneficiaries who enrolled in a plan whose sponsor entered into a contract with the Secretary, pursuant to CMS's request for proposals (RFP) issued on February 17, 2009 relating to Medicare Part D retroactive coverage for certain low-income beneficiaries, or a similar subsequent request for such proposals, would not be included in this definition.

For each month, beginning with January 2011, each PDP and MA-PD plan would be required to report to the Secretary information on the number and value of claims the plan has re-adjudicated on behalf of a beneficiary due to the beneficiary becoming retroactively eligible for the subsidy, the affected beneficiaries' Medicare identification number, and an attestation to the Administrator of CMS regarding the total amount of reimbursement the plan has provided to beneficiaries for premiums and cost-sharing that the beneficiary overpaid and for which the plan received payment.

Reason for Change

Through existing authority under current law, the Secretary has established a requirement that Part D plans make appropriate retroactive reimbursements to beneficiaries and third parties. This provision would enact and clarify that process. It also would implement oversight procedures of the retroactive reimbursement process to allow the Secretary to better determine whether the payments for this retroactive coverage from CMS to the Part D plans are accurately and consistently reimbursed to beneficiaries and third parties.

Effective Date

January 1, 2011.

Sec. 1205. Intelligent Assignment in Enrollment

Current Law

Special enrollment rules apply to individuals eligible for the Part D low income subsidy. Generally, there is a two-step process for low-income persons to gain Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan.

According to Section 1860D–14 of the SSA, full-benefit dual-eligible individuals who have not elected a Part D plan are to be auto-enrolled into one by CMS. If there is more than one plan available that has a monthly beneficiary premium that does not exceed the premium assistance amount under the low-income subsidy, the beneficiary is to be enrolled on a random basis among all such plans in the PDP region. The individual has the option of declining or changing such enrollment.

Some dual eligibles may find that they are auto-enrolled in a plan that may not best meet their needs. For example, it is possible

that the specific drug(s) that a beneficiary is currently taking is not covered by the new plan. For this reason, beneficiaries are able to change enrollment at any time, with the new coverage effective the following month.

Proposed Law

The Secretary would be given the option to use an "intelligent assignment" process as an alternative to the random assignment process. The intelligent assignment process would be designed to maximize the access of full-benefit dual eligibles to necessary prescription drugs while minimizing costs to the individual and to the program to the greatest extent possible. The process would need to take into account the extent to which prescription drugs necessary for the individual are covered, the use of prior authorization or other restrictions on access to coverage of drugs, and the overall quality of a prescription drug plan.

Reason for Change

The Medicare Modernization Act prohibited CMS from using any methodology other than random assignment when automatically enrolling full benefit dual eligibles into Part D plans. While this process results in beneficiaries enrolled in the lowest cost plans based on monthly premium, it does not take into consideration whether this vulnerable population is enrolled in quality plans that cover the beneficiaries' necessary medications. While dual eligibles have the option of enrolling in a different plan, this is a particularly frail population that may not have the capacity to evaluate and choose among all of the available plans. The Committee's intention is that CMS evaluate methodologies for intelligently assigning dual eligibles to Part D plans based on cost—but also on formulary coverage for beneficiaries' needed prescriptions, use of prior authorization and other restrictions, and quality measures—and to implement if the Secretary determines that a methodology could both minimize cost to the program and maximize access of dual eligibles to needed prescription drugs.

Effective Date

January 1, 2012.

Sec. 1206. Special Enrollment Period and Automatic Enrollment Process for Certain Subsidy Eligible Individuals

Current Law

In general, a Medicare beneficiary who does not enroll in Part D during his or her initial enrollment period may enroll only during the annual open enrollment period, which occurs from November 15 to December 31 each year. Coverage begins the following January 1. Beneficiaries already enrolled in a Part D plan may change their plans during the annual open enrollment period.

There are a few additional, limited occasions when an individual may enroll in or disenroll from a Part D plan or switch from one Part D plan to another, called special enrollment periods (SEPs). For example, SEPs are allowed for individuals who involuntarily lose creditable coverage, are subject to a federal error in enroll-

ment, meet certain exceptional conditions as established by the Secretary, or are a full-benefit dual eligible individual.

Proposed Law

The provision would establish a new special enrollment period for persons deemed to be low-income subsidy eligible individuals. The provision would also require the Secretary to use an automatic assignment process to enroll low-income beneficiaries who failed to enroll in a prescription drug plan or MA-PD plan during the special enrollment period. This assignment process would be identical to that used for full-benefit dual eligibles. The individual would have the option of declining or changing such enrollment.

Reason for Change

Under current statutory authority, the Secretary has established a continuous SEP whereby upon becoming eligible for Part D, the Secretary automatically enrolls full benefit dual eligibles into a Part D plan; the individual retains the right to decline or change enrollment in any month. The Secretary has also expanded this SEP to include all individuals who are eligible for the Part D low-income subsidy (LIS). This provision codifies CMS' interpretation of current law with regard to allowing an SEP and automatic enrollment process for all LIS-eligible beneficiaries, and harmonizes the auto-enrollment process created in section 1205 of the Act for full-benefit dual eligibles with other LIS-eligible beneficiaries (i.e. permitting CMS to use an intelligent assignment process). Although the MMA limited the statutory SEP to full-benefit dual eligibles, the Committee agrees with CMS that this SEP and subsequent automatic enrollment into a Part D plan should also apply to other LIS-eligible beneficiaries as a guarantee that individuals are properly enrolled in a Part D plan and able to access needed medications.

Effective Date

Subsidy determination made for months beginning with January 2011.

Sec. 1207. Application of MA Premiums Prior to Rebate in Calculation of Low Income Subsidy Benchmark

Current Law

The federal government pays up to 100% of the Part D premiums for LIS beneficiaries who are enrolled in "benchmark" plans. A Part D plan qualifies as a benchmark plan if it offers basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount. The regional low-income benchmark premium amount, calculated annually, is the weighted average of all premiums in each of the 34 prescription drug plan (PDP) regions for basic prescription drug coverage, or the actuarial value of basic prescription drug coverage for plans that offer enhanced coverage options, or for Medicare Advantage Prescription Drug (MA–PD) plans, the portion of the premium attributable to basic prescription drug benefits.

Under the Medicare Advantage program (Part C), plans bid to offer Parts A and B coverage to beneficiaries. CMS bases the Medi-

care payment for a MA plan on the relationship between its bid and a benchmark (different from the LIS benchmark). The MA benchmark represents the maximum amount the federal government will pay a plan for providing required Medicare benefits. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75% of the difference between the benchmark and the bid. The rebate must be used to provide additional benefits to enrollees, reduce Medicare cost sharing expenses, or reduce a beneficiary's monthly Part B, prescription drug, or supplemental premium (for services beyond the required Medicare benefits).

MA plans offering prescription drug coverage submit a separate bid for the Part D portion. Payment for the portion of the premium attributable to basic prescription drug benefits is calculated in the same way as that for stand-alone PDPs; however the MA plan may choose to apply some of its Part C rebate payments to lower the Part D premium.

Proposed Law

The statute would be modified to exclude the Part C rebate amounts from the MA-PD plan premiums when calculating the low-income regional benchmark for subsidy determinations made for months beginning with January 2011.

Reason for Change

CMS' current methodology for determining which plans are eligible for automatic enrollment of LIS-eligible beneficiaries results in millions of beneficiaries being switched into different Part D plans each year. This is disruptive and confusing for beneficiaries. Excluding the rebate portion of the premium—which goes solely to providing extra benefits, like gym memberships—from the calculation of the LIS benchmark which determines the plans eligible for auto-enrollment, will lessen the number of beneficiaries who have to switch plans each year because their plan's premium exceeds the LIS benchmark. This is one step toward ensuring that frail beneficiaries have continuity in their Part D plan from year-to-year and maintain adequate access to needed prescription drugs.

Effective Date

Subsidy determination made for months beginning with January 2011.

Subtitle B—Reducing Health Disparities

Sec. 1221. Ensuring Effective Communication in Medicare

Current Law

Congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin. The United States Supreme Court has treated discrimination based on language as national origin discrimination. Therefore, recipients of federal funds (including hospitals, nursing homes, state Medicaid agencies, managed care organizations, home health agencies, health service providers, human service organizations, and any other health or human services federal fund recipient, as well as subcontractors, vendors, and subrecipients) are required to take

reasonable steps to ensure that persons with limited English proficiency have meaningful access to programs and activities. The Department of Health and Human Services has issued guidance, including a four-factor analysis, that implicates the "mix" of language services that should be offered, including oral and written interpretation services.

Proposed Law

The provision would require the Secretary of the Department of Health and Human Services to conduct a study to examine the extent to which Medicare providers utilize, offer, or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services. The study would include an analysis of: ways to develop and structure appropriate payment systems for language services for Medicare providers; the feasibility of adopting a payment methodology for on-site interpreters; the feasibility of Medicare contracting directly with agencies that provide off-site interpretation, including telephonic and video interpretation; the feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments when a patient is LEP; and how each of these options would be funded. The study would also include an analysis of the extent to which providers under Medicare Parts A, B, C, and D utilize, offer, or make available language services for beneficiaries with LEP; and the nature and type of language services provided by states for Medicaid recipients, and the extent to which such services could be utilized by Medicare providers.

The potential payment systems included in the analysis could allow variations based on types of service providers, available delivery methods, and costs for providing language services. Factors could include: the type of language service provided, such as the provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter; the type of interpretation provided, such as in-person, telephonic, video interpretation; the methods and costs of providing language services, including the costs of providing language services with internal staff and/or through contract with external independent contractors or agencies; providing services for languages not frequently encountered in the United States; and providing services in rural areas.

The Secretary would be required to submit a report to appropriate committees of Congress not later than 12 months after the date of enactment of this Act. The Paperwork Reduction Act would not apply for purposes of carrying out this study. The necessary funds to conduct the study would be authorized to be appropriated.

This provision also would authorize the Secretary to apply sanctions, such as civil money penalties, suspension of enrollment, and suspension or payments, to Medicare Advantage organizations that substantially fail to provide required language services to LEP beneficiaries enrolled in their plans.

Reason for Change

Studies have shown that language barriers can have deleterious effects on patient care. Patients who face such barriers are less

likely than others to have a usual source of medical care; they receive preventive services at reduced rates; and they have an increased risk of nonadherence to medication. Ad hoc interpreters, including family members, friends, untrained members of the support staff, and strangers found in waiting rooms or on the street, are commonly used in clinical encounters. However, such interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences. This policy is intended to evaluate the effectiveness of culturally and linguistically appropriate care by directing the Secretary to conduct a study that examines the extent to which Medicare providers utilize, offer or make available language services for beneficiaries who are limited English proficient. The study will also evaluate ways that Medicare should develop payment systems for language services.

Effective Date

Date of enactment.

Sec. 1222. Demonstration to Promote Access for Medicare Beneficiaries with Limited English Proficiency by Providing Reimbursement for Culturally and Linguistically Appropriate Services

Current Law

No provision.

Proposed Law

Not later than 6 months after the completion of the study described in section 1221, the Secretary, acting through the CMS, would be required to carry out a demonstration program under which the Secretary would award no fewer than 24 three-year grants to eligible Medicare providers to improve effective communication between providers and Medicare beneficiaries living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. Using the results of the completed study, the Secretary would adjust, as appropriate, the distribution of grants to target Medicare beneficiaries who are in the greatest need of language services. The Secretary would be required to not authorize a grant larger than $500,000 over three years for any grantee.

To be eligible to receive a grant, an entity would be required to be a Medicare provider of services under Parts A or B, a Medicare Advantage organization offering a Medicare part C plan, or a sponsor of a part D prescription drug plan (PDP). To the extent feasible, the Secretary would award at least 6 grants each to part A providers, part B providers, part C organizations, and to prescription drug sponsors. The Secretary would be required to give priority to applicants that have developed partnerships with community organizations or agencies with experience in language access. The Secretary would also need to ensure that grantees represent variations in types of language services, languages needed and their frequency of use, urban and rural settings, at least two geographic regions as defined by the Secretary, and at least two large urban areas with diverse populations.

The grantee would be required to use the grant funds to pay for the provision of competent language services to LEP Medicare beneficiaries. Such services may be provided through on-site interpretation, telephonic interpretation, video interpretation, or direct provision of health care or health care-related services by a bilingual health care provider. The grantee may also use bilingual providers, staff, or contract interpreters. The grantee may use up to 10% of the grant funds to pay for administrative costs associated with the provision of competent language services and for required reporting. Grantees that are part C organizations or PDP sponsors would be required to ensure that their network providers, including physicians and pharmacies, receive at least 50% of the grant funds to pay for the provision of language services.

The payments to grantees would be calculated based on the estimated numbers of LEP Medicare beneficiaries in a grantee's service area, using the most recently available data from the Bureau of Census or other state-based study on the number of individuals served by the grantee who speak English less than "very well", or using the grantee's own data on Medicare beneficiaries primary language if the Secretary determines such data to be reliable. Payment would only be provided to grantees that report their costs of providing language services and may be modified annually at the discretion of the Secretary. If the grantee does not provide the reports for the first year of a grant, the Secretary would be able to terminate the grant and to solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

Payments would only be provided to grantees that utilize competent bilingual staff or competent interpreter or translation services which meet the state standards currently in effect if the grantee operates in a state that has statewide health care interpreter standards. For grantees operating in states without such standards, the grantee would be required to utilize interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice. This requirement would not apply if a beneficiary requests the use of family, friends, or other persons untrained in interpretation and the grantee documents the request in the beneficiary's record. This requirement would also not apply in the case of a medical emergency where the delay associated with obtaining an interpreter would jeopardize the health of the patient. Emergency rooms and other entities that regularly provide health care services in medical emergencies, would, however not be exempt from the requirement to provide interpreter and translation services without undue delay.

Grantees would also be required to: ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery; ensure the linguistic competence of bilingual providers; offer and provide appropriate language services at no additional charge to each LEP patient at all points of contact, in a timely manner during all hours of operation; notify Medicare beneficiaries of their right to receive language services in their primary language; post signage in the languages of the commonly encountered group or groups present in the organization's service area; and ensure that primary language data are collected for recipients of language services (if the recipient of lan-

guage services is a minor or is incapacitated, the primary language of the parent or legal guardian would be collected and utilized).

Grantees would be required to provide the Secretary with reports at the end of each year of the grant. The report would include (1) the number of Medicare beneficiaries to whom language services are provided; (2) the languages of those Medicare beneficiaries; (3) the types of language services provided; (4) the type of interpretation; (5) the methods of providing language services; (6) the length of time for each interpretation encounter; and (7) the costs of providing language services.

LEP Medicare beneficiaries would not be required to pay cost-sharing or co-pays for language services provided under this demonstration.

The Secretary would be required to conduct an evaluation of the demonstration program and submit a report to the appropriate committees of Congress not later than 1 year after the completion of the program. The report would include an analysis of the patient outcomes and costs of furnishing care to the LEP Medicare beneficiaries participating in the project compared to those not participating; the effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and health outcomes; and recommendations regarding the extension of the project to the entire Medicare program.

This provision would not limit existing obligations of recipients of federal financial assistance under title VI of the Civil Rights Act of 1964. An amount of $16 million would be authorized to be appropriated for each fiscal year of the demonstration program.

Reason for Change

Although certain recipients of federal funds are required to offer language services, Medicare does not reimburse for these services. Testing alternative methods of delivering culturally and linguistically appropriate services will enable Medicare to apply best practices and vastly improve both access to and quality of services to beneficiaries with limited English proficiency.

Effective Date

The demonstration would begin not later than 6 months after the completion study described in section 1221.

Sec. 1223. IOM report on Impact of Language Access Services

Current Law

No Provision.

Proposed Law

Under this provision, the Secretary of HHS would be required to enter into an arrangement with the Institute of Medicine (IOM) under which the IOM would prepare a report on the impact of language access services on the health and health care of limited English proficient populations. The report would be issued not later than 3 years after the date of the enactment of the Act.

The report would include recommendations on the development and implementation of policies and practices by health care organi-

zations and providers for limited English proficient patient populations, a description of the effect of providing language access services on quality of health care and access to care and reduced medical error, and a description of the costs associated with, or savings related to, the provision of language access services.

Sec. 1224. Definitions

Current Law

No provision.

Proposed Law

This provision provides the following definitions to be applied in sections 1221 through 1223.

The term bilingual would mean a person who has a sufficient degree of proficiency in two languages and can ensure that effective communication can occur in both languages.

The term competent interpreter services would be defined as a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the intended meaning. The interpreter would be required to know health and health-related terminology.

The term competent translation services would mean a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator would be required to know health and health-related terminology.

The term effective communication would mean an exchange of information between the provider of health care or health care-related services and the LEP recipient of such services that enables the LEP individual to access, understand, and benefit from health care or health care-related services.

The terms interpreting/interpretation would be defined as the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

The term health care services would mean services that address physical as well as mental health conditions in all care settings.

The term health care-related services would be defined as human or social services programs or activities that provide access, referrals or links to health care.

The term language access would mean the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

The term language services would be defined as the provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

The term limited English proficient (LEP) would be defined as an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care-related services.

The term Medicare beneficiary would mean an individual entitled to benefits under Medicare part A or enrolled in Medicare part B.

The term Medicare program would mean the programs under parts A through D of title XVIII of the Social Security Act (SSA).

The term service provider would be defined as all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the SSA.

Reason for Change

To provide definitions for certain terms used in Subtitle B.

Subtitle C—Miscellaneous Improvements

Sec. 1231. Extension of Therapy Caps Exceptions Process

Current Law

Current law places two annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) extended the exceptions process for therapy caps through December 31, 2009.

Proposed Law

The proposal would extend the exceptions process for therapy caps for 2 years, through December 31, 2011.

Reason for Change

There is wide consensus that the therapy cap created in the Balanced Budget Act of 1997 is not good health policy, yet to permanently repeal the cap is a very costly proposition. Extending the exceptions process for two additional years will provide Congress with an opportunity to consider alternative options to the current process.

Effective Date

January 1, 2010.

Sec. 1232. Extended Months of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients and Other Renal Dialysis Provisions

Current Law

To be eligible for Medicare, one must be (1) 65 years or older and eligible to receive Social Security; or (2) under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or (3) have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease); or (4) have end-stage renal disease (ESRD).

Coverage for beneficiaries with ESRD generally begins in the fourth month of dialysis treatments or the month of a kidney transplant. After receiving a kidney transplant, individuals are prescribed immunosuppressive drugs to reduce the risk of their immune system rejecting the new organ. These drugs generally need to be taken for the rest of the individual's life.

Under Medicare Secondary Payer (MSP) rules, Medicare is prohibited from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. For individuals with Medicare entitlement based solely on ESRD, MSP rules apply for those covered by an employer-sponsored group plan, regardless of the employer size or current employment status. Any group health plan coverage these beneficiaries receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility. After 30 months, Medicare becomes the primary insurer.

If a beneficiary already had Medicare because of age or disability before the onset of end-stage renal disease, or if an individual became eligible for Medicare because of age or disability after receiving a transplant paid for by Medicare, Medicare will continue to pay for immunosuppressive drugs with no time limit. However, if a beneficiary qualifies for Medicare only because of kidney failure, Medicare, together with coverage of the immunosuppressive drugs, ends 36 months after the month of the successful transplant. After that period, kidney recipients must pay for immunosuppressive drugs through private insurance, public or pharmaceutical programs, or pay out-of-pocket until they reach 65 and qualify for Medicare because of age.

Individuals with ESRD are eligible for all Part B Services. Part B also covers their dialysis services, drugs, and biologicals, including erythropoiesis stimulating agents, diagnostic laboratory tests, and other items and services furnished to individuals for the treatment of ESRD.

Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at a facility or in the patient's home. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) requires the Secretary to implement a bundled payment system, making a single payment for Medicare renal dialysis services, to be phased in over 4 years beginning January 1, 2011. The bundled payment will include (1) items and services included in the composite rate as of December 31, 2010; (2) erythropoiesis stimulating agents for the treatment of ESRD; (3) injectable biologicals and medications that were paid for separately under Part B, (before bundling) and any oral equivalent to such medications; and (4) diagnostic laboratory tests and other items and services furnished to individuals for the treatment of ESRD. Dialysis facilities will have the opportunity to opt out of the phase-

in and be paid under the new bundled system starting in 2011. The new law also creates a quality incentive payment program that ties payments to certain quality measures including anemia management, dialysis adequacy, patient satisfaction, and bone mineral metabolism.

Proposed Law

This provision would amend SSA title II (Old Age, Survivors and Disability Insurance) to (1) continue entitlement to prescription drugs used in immunosuppressive therapy furnished to an individual who receives a kidney transplant for which payment is made under Medicare, and (2) extend Medicare secondary payer requirements for ESRD beneficiaries.

It would also amend title XVIII (Medicare) of SSA to apply special rules to kidney transplant recipients who receive additional coverage for immunosuppressive drugs whose eligibility for benefits would have ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs. Such individuals would be deemed to be enrolled under Medicare Part B and would be responsible for the full amount of the applicable premiums, deductibles, and co-insurance payments that are not covered under the Medicare savings program.

The provision makes several changes to Medicare coverage for ESRD patients under Section 1881 of SSA. The provision specifies that oral drugs that are not the oral equivalent of an intravenous drug would be included in the drugs and biologicals provided as part of the renal dialysis services covered by Medicare. The provision also would allow providers of renal dialysis services to make an election with respect to 2011, 2012, or 2013, prior to the first date of such year, to be excluded from the phase in of the prospective rate (or the remainder of the phase in) and be paid entirely based on the prospective rate. Additionally, the provision changes the performance standards of ESRD providers from the "lesser of" to the "greater of" the performance of such provider or facility or a performance standard based on the national performance rates for such measures in a period determined by the Secretary.

Reason for Change

Under current law, Medicare coverage for patients who have had a kidney transplant ends after 36 months, unless the patients are otherwise eligible for Medicare because of age or disability. The Committee believes this is a penny-wise, pound-foolish policy. Patients who receive a kidney transplant must continue taking immunosuppressive drugs for the rest of their lives in order to avoid rejecting the new organ. However, when Medicare coverage ends, beneficiaries must find another way to pay for immunosuppressive drugs, which cost $5,000 to $13,000 per year. A recent survey of professionals treating kidney transplant patients found that almost 90 percent of patients have difficulty paying for these drugs once Medicare coverage ends, and 65 percent fail to take their drugs as prescribed. Once a patient stops taking the drugs, his or her body will almost immediately reject the transplanted kidney and the patient will either need another kidney transplant or require dialysis treatments for the rest of his or her life. These are costs that would also be incurred by the Medicare program.

A recent GAO study found that the Medicare cost for a beneficiary who has a failed transplant is five times greater per year ($50,938) than a patient with a functioning transplant ($8,550). This cost, as well as quality of life for the patient, underscores the benefits to the Medicare program and kidney transplant patients from the extension of coverage of immunosuppressive drug coverage in this section.

This section also includes a technical clarification that oral drugs furnished to individuals for treatment of ESRD are included in the bundled payment. This authority already exists under current law (see statement of Health Subcommittee Chairman Pete Stark in the Congressional Record on June 24, 2008), however, clarification of existing authority ensures that clinical and financial decision-making for dialysis patients are aligned, so that providers put patients before profits; advances better adherence to drug regimens; lowers beneficiary cost-sharing; and is consistent with statements made by MedPAC.

As stated by MedPAC in questions submitted for the record to the Committee on Ways and Means, providers otherwise will have a financial incentive to shift patients to Part D drugs even though that may not be in the clinical best interest of the patient. Beneficiaries would then be subject to a double-payment, as they would have to pay coinsurance for the ESRD bundle and a second coinsurance for the drugs under Part D. Medicare would also be paying twice, once for drugs in the bundle and once for drugs under Part D. It is for this reason that CBO estimates savings for this provision: the Medicare program will successfully avoid a doublepayment. MedPAC also points out that including these oral drugs in the bundle may improve dialysis quality for patients by improving patient adherence to drug regimens.

The Committee notes that some providers are concerned about their ability to provide these drugs. The Committee understands that the two large dialysis providers have in-house pharmacies, and thus dispensing these drugs is not a problem. Dialysis providers who do not have in-house pharmacies will already need to find a way to provide oral drugs since oral drugs that have IV equivalents are also in the bundle. They can do so by contracting out for pharmacy services, as they currently do for lab services. The original statute recognized the potential cost burden of this activity when it created a 10 percent adjustment for low-volume providers—the purpose of this adjustment is to help low-volume providers cover additional costs such as possible contracting out of services.

This section also modifies the restriction around when facilities can decide to opt into receiving the bundled payment during the four years before it is fully implemented in 2014. Currently, facilities can only opt-in during the first year. The Committee believes that bundled payments encourage more efficient provision of care and will improve quality of care. To the extent that a provider decides after one year of phased-in payments that they would like to opt fully into the bundle, there is no reason to stop them from doing so. Therefore, this section would permit all facilities to opt-in during any year of the four year phase-in. The Committee understands from the CMS Office of the Actuary that this change will lower the budget neutrality adjustment needed because of the

phase-in, so any concerns about uncertainty in payment rates due to this change will only move in the direction of improving payment rates.

The Committee believes that implementation of an ESRD bundle must be accompanied by a rigorous system of quality measurement and incentives in order to ensure patients receive appropriate levels of care. However, the Committee is concerned that the performance measure in the existing statute for the initial period for anemia management sets the bar so low that there is no requirement for facilities to improve performance. The Committee notes that by the time bundling is implemented, providers will have had several years to adjust practice patterns in response to FDA black box label changes that occurred in 2007 and 2008, and thus has strengthened the quality measurement in the initial period.

Effective Date

Subsection (a) is effective January 1, 2012. Subsection (b) is effective January 1, 2011.

Sec. 1233. Advance Care Planning Consultation

Current Law

Section 1866(f) of Title XVIII of the SSA requires certain institutional providers and prepaid plans that participate in Medicare to follow specified policies and procedures in regard to advance directives. Specifically, it requires states to develop written descriptions of relevant state law concerning advance directives that would be distributed by Medicare participating institutional providers or organizations. Current law also mandates that Medicare participating providers distribute information about advance directives according to the timing of certain medical or health-related events. Hospitals and nursing homes must provide this information to individuals at the time of admission; home health agencies must provide it in advance of the individual coming under the care of such agencies; hospice providers must provide this information at the time of the initial receipt of hospice care; and prepaid health plans must provide it to individuals upon enrollment. Medicare-certified providers that do not comply with these requirements may have payments withheld by the Secretary. Furthermore, state laws that allow for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive, shall supersede these requirements.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) added "end-of-life planning" to the initial preventive physical exam that Medicare beneficiaries receive upon enrollment in Medicare. MIPPA also defines "end-of-life planning" to mean verbal or written information regarding: an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

The Physician Quality Reporting Initiative (PQRI), the voluntary individual reporting program that provides an incentive payment to eligible professionals (EPs) who satisfactorily report data on

quality measures for covered Medicare Physician Fee Schedule (PFS) services, was established by Section 1848(k)(1) of the SSA. PQRI requires eligible professionals to report on certain quality measures in order to receive an incentive payment equal to 2.0% of covered professional services. The payment incentives were established by Section 1848(m)(1)(A) and (B) of the SSA. Participation in PQRI is voluntary. The PQRI program is not specific to end-of-life care, but it does include several geriatrics measures, including one measure which specifically addresses advance care plans. This measure aims to assess whether a patient has an advance care plan or surrogate decision maker documented in their medical record.

CMS was mandated by the Balanced Budget Act of 1997 (P.L. 105–33) to develop and organize activities to educate beneficiaries about the Medicare program. Specifically, the Act mandated that CMS establish a toll-free helpline, mail written information to beneficiaries on Medicare and their options to enroll in private plans, create a Medicare website, and support a community outreach program to help beneficiaries and their caregivers make informed health care decisions. CMS conducts these activities as part of its National Medicare and You Education Program (NMEP). The Medicare & You Handbook is one component of the agency's NMEP program.

The Handbook, which is produced in English and Spanish, is updated on an annual basis and mailed to beneficiaries every Fall. Handbooks are mailed monthly to newly eligible beneficiaries.

Proposed Law

The provision would amend Section 1861 of Title XVIII of the SSA under Medicare to add new language concerning an advance care planning consultation and add a new subsection describing these consultations. It would amend Section 1848(j)(3) to provide payment to physicians for an advance care planning consultation under Medicare. The provision would also expand the physician quality reporting initiative for end-of-life care. The Medicare & You Handbook would be updated to include an explanation of various end-of-life care planning terms and resources.

The term "advance care planning consultation" would mean a consultation between the individual and an individual's physician, nurse practitioner or physician assistant as specified regarding advance care planning if the individual involved has not had such consultation within the last 5 years. Medicare's initial preventative physical examination would not be considered an advance care planning consultation for purposes of applying the 5-year limitation. Such consultation would be authorized to be conducted more frequently if there is a significant change in an individual's health.

Such a consultation would be required to include an explanation by the practitioner of advance care planning; advance directives and their uses; role and responsibilities of a health care proxy; the continuum of end-of-life care services and supports available and Medicare benefits that are available. Practitioners would be required to provide a list of national and State-specific resources to assist consumers and their families with advance care planning. The advance care planning consultation would also be required to include an explanation of orders regarding life sustaining treat-

ment or similar orders as specified. The Secretary would be required to limit this requirement to consultations furnished in a State in which all legal barriers for such orders have been addressed and that has a program in effect as specified. Such consultation is authorized to include the formulation of an order regarding life-sustaining treatment or similar order.

The term "order regarding life sustaining treatment" would mean, with respect to an individual, an actionable medical order relating to the treatment of that individual that (1) is signed and dated by a physician or another health care professional as specified and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care; (2) effectively communicates the individual's preferences regarding life sustaining treatment; (3) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and (4) may incorporate any advance directive if executed by the individual.

The level of life treatment indicated may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items (1) the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems; (2) the individual's desire regarding transfer to a hospital or remaining at the current care setting; (3) the use of antibiotics; and (4) the use of artificially administered nutrition and hydration.

The provision would modify Section 1848(j)(3) of the SSA (concerning definitions for physicians' services) to include Medicare payment for physicians' services with respect to an advance care planning consultation. It would amend Section 1862(a)(1) of the SSA (concerning exclusions from coverage and Medicare as secondary payer) to add that no Medicare payment would be authorized for expenses incurred in the case of an advance care planning consultation which is performed more frequently than covered under such section. It would also amend Section 1862(a)(7) to include an advance care planning consultation as an otherwise allowable expense, among the list of certain expenses excluded from coverage. The amendments would apply to advance care planning consultations furnished on or after January 1, 2011.

The provision would amend Section 1848(k)(2) of the SSA to add new language that would require the Secretary, for the purposes of reporting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if available and appropriate. Such measures would be required to measure both creation and adherence to orders for life-sustaining treatment. The Secretary would be required to publish these proposed measures in the Federal Register and provide for a period of public comment before finalization.

No later than 1 year after the date of enactment, the Secretary would be required to update the online version of the Medicare & You Handbook to include an explanation of advance care planning and advance directives, including living wills, durable power of attorney, orders of life-sustaining treatment, and health care proxies.

It would also be updated to include a description of Federal and State resources available to assist individuals and their families with advance care planning and advance directives, including available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965; website links or addresses for State-specific advance directive forms; and any additional information, as determined by the Secretary. The Secretary would also be required to include the above information in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 1 year after the date of enactment.

Reason for Change

It is vitally important that physicians provide patient-centered care that follows the express wishes of each patient. Unfortunately, in some circumstances patient preferences may not be known by the treating physician and the patient is unable to express his or her wishes to that physician. Moreover, patients are often unaware of the different treatment options available in the event they need life sustaining treatment.

Adding advanced care planning consultation to the list of Medicare covered services will help address those problems. These consultations are designed to assist patients to make informed decisions about the full range of life sustaining treatment options available and ensure that treating physicians are fully aware of patients' wishes. The provision does not require any beneficiary to receive such consultations and does not prescribe or restrict the advanced care treatment options available to any beneficiary.

Adding quality measures on advance care planning to Medicare's quality reporting initiatives will provide important data about the use of such counseling. Adding information about advance care planning, living wills and advance directives to the Medicare & You Handbook will support efforts to ensure that patient wishes are followed regarding life sustaining treatment.

Effective Date

January 1, 2011, for advance care planning consultations and reporting data; one year after date of enactment for changes to Medicare & You Handbook.

Sec. 1234. Part B Special Enrollment Period and Waiver of Limited Enrollment Penalty for TRICARE Beneficiaries

Current Law

TRICARE beneficiaries who are eligible for Medicare Part A must accept and pay for voluntary Medicare Part B in order to retain their TRICARE Coverage. Medicare functions as the primary payer and TRICARE serves as a supplement. This requirement is the result of many changes in the law the last of which came in the National Defense Authorization Act of 2001 (P.L. 106–386) which created the TRICARE for Life program. With the establishment of TRICARE for Life and the concomitant need to enroll in Medicare Part B, there became concern about coordination between the two programs and the potential for penalties for late enroll-

ment in Part B. To address this concern, section 625 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) waived the Part B enrollment penalty for eligible retirees who enrolled in Part B prior to December 31, 2004.

Explanation of Provision

This provision creates a special 12 month enrollment period in which military retirees who are eligible for Medicare by reason of disability or End Stage Renal Disease (ESRD) who have not yet enrolled in Medicare Part B can enroll in Part B, thus becoming eligible for TRICARE for Life, without incurring a Medicare late enrollment penalty. The provision would apply to elections made on or after the date of enactment of the Act.

This provision would also require the Secretary of HHS to establish a method for providing rebates for late enrollment penalties that were charged to certain disabled and End Stage Renal Disease (ESRD) beneficiaries who enrolled during or after January 2005 and before the month of enactment of this Act.

Reason for Change

When beneficiaries refuse Medicare Part B coverage, they are quickly disenrolled from Medicare and TRICARE and are left without any insurance coverage except for Medicare Part A Hospital coverage. Often, beneficiaries refuse Medicare Part B without proper knowledge and understanding of the consequences and only realize that they do not have comprehensive health insurance when they present at the doctor's office. Once beneficiaries have refused their Part B coverage, they must wait many months until the next Medicare general enrollment period to reenroll. This issue has become a particular concern for the severely disabled population who refuse Medicare Part B after receiving Medicare coverage retroactively because of a delayed disability determination. The provision is designed to provide a permanent grace period and allow certain service members to quickly reenroll in Medicare without penalty after initially refusing Part B to ensure that they have access to the vital medical services that they need.

Effective Date

The special enrollment period and waiver of penalty will be effective for elections made on or after the date of enactment of this Act.

Sec. 1235. Exception for Use of More Recent Tax Year in Case of Gains From Sale of Primary Residence in Computing Part B Income-Related Premium

Current Law

Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. Beginning in 2007, Part B premiums are income related, requiring higher-income enrollees to pay a higher percentage of Part

B costs. Beneficiaries experiencing major life events may apply to use a more recent tax year for determination of the income-related premium. Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs.

Proposed Law

This provision treats the sale of a primary residence as a major life event for purposes of qualifying for the use of a more recent tax year. This modification would apply to premiums and payments for years beginning with 2011.

Reason for Change

The Committee is aware of situations where Medicare beneficiaries are subject to the income related Part B premium due to a capital gain from the sale of a primary residence. These gains may be incurred after owning the home for several decades, and regardless of whether the beneficiary puts the proceeds into an annuity that pays them a monthly amount. This provision appropriately recognizes that sale of a primary residence should be treated as a major life changing event for purposes of determining whether a beneficiary is subject to the income related premium.

Effective Date

October 1, 2011.

Sec. 1236. Demonstration Program on Use of Patient Decisions Aids

Current Law

Current law does not explicitly address patient decision aids, which are information tools to help patients understand health care options, and make informed choices that take into account their lifestyle, preferences, and beliefs. A related concept is shared decision making (referred to by many other names as well), meaning the cooperation of providers and patients in making health care decisions.

Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) requires the Secretary to carry out a Medicare quality demonstration program, which would, among other things, encourage shared decision making. Eligible entities include physician groups, integrated health systems, or regional coalitions of the same. Projects approved under this demonstration are expected to achieve significant improvements in safety, effectiveness, efficiency, patient-centeredness (i.e., shared decision making), timeliness, and equity, the six aims for quality improvement identified by the Institute of Medicine. Two demonstrations have been approved and will begin in 2009. Two others are in the final review process.

In addition, under their general authorities, the Agency for Healthcare Research and Quality (AHRQ) and Centers for Disease Control and Prevention (CDC) conduct research on the application and use of shared decision making, including the use of patient decision aids.

Proposed Law

This section would require the Secretary to conduct a Medicare demonstration program to determine if using patient decision aids would improve beneficiaries' understanding of their medical treatment options. The program would enroll not more than 30 eligible providers, with preference given to providers that have documented experience in using patient decision aids, and that have the necessary information technology infrastructure. Eligible providers would be required to provide follow-up counseling visits after beneficiaries have viewed decision aids, to address questions about subsequent medical care and the beneficiary's preferences. The Secretary would have to provide for the development of a code(s) and reimbursement amounts for the follow-up counseling. Eligible providers would be responsible for the costs of selecting, purchasing, and delivering patient decision aids, and reporting data on quality and outcome measures.

To carry out the program, the Secretary would be required to use funds from the Federal Supplementary Medical Insurance Trust Fund, and would be authorized to waive requirements under SSA Titles XI (general and administrative provisions) and XVIII (Medicare). Within 12 months of program completion, the Secretary would be required to report to Congress regarding the effects of the program on health quality, utilization of health care services, and quality of life; and any recommendations for legislation and administrative action.

Eligible providers would be: (A) a primary care practice; (B) a specialty practice; (C) a multispecialty group practice; (D) a hospital; (E) a rural health clinic; (F) a Federally Qualified Health Center; (G) an integrated delivery system; [or] (H) a State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids. The provision would define "patient decision aid" to mean "an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences;" and "shared decision making" to mean "a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan."

Reason for Change

Studies have suggested that quality of care is improved and costs can be reduced when patients facing medical procedures use decision aids such as pamphlets and videos to receive information about treatment options available. The demonstration program under this section would test this approach within the Medicare population, with an emphasis on physician follow-up visits to discuss information disseminated by such decision aids.

Effective Date

Date of enactment.

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

Sec. 1301. Accountable Care Organization Pilot Program

Current Law

No current provision. In April 2005, the Centers for Medicare and Medicaid Services initiated the Physician Group Practice demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service beneficiaries.

Proposed Law

A new section 1866D would be added to the Social Security Act (SSA) to establish the accountable care organization pilot program. The Secretary would conduct a pilot program to test different payment incentive models intended to reduce Medicare's expenditure growth and improve health outcomes. The pilot would promote accountability for services provided to a Medicare patient population, coordinate Medicare's part A and B items and services, encourage investment in infrastructure and the redesign of care processes, and reward high quality, efficient physician practices.

A qualifying accountable care organization (qualifying ACO) would be a group of physicians or other physician organizational model which is organized, at least in part, for the purpose of providing physician services and meet other specified standards. A qualifying ACO could include other practitioners such as nurse practitioners or physician assistants, a hospital or multiple hospitals or any other provider or supplier (furnishing Medicare covered services) that is affiliated with the ACO under an arrangement structured to coordinate care. A physician would include any individual who furnishes services for which payment may be made as physicians' services except as otherwise determined by the Secretary. With respect to a qualifying ACO, other physician organizational model would mean any model of organization under which physicians enter into agreements with other providers for the purposes of participation in the pilot program in order to provide high quality, efficient health care services and share in the program's incentive payments. No requirements under this section would prevent a qualifying ACO from furnishing items or services for which Medicare payment is not made in order to achieve performance goals under the pilot program.

A qualifying ACO would meet the following requirements: (1) have a legal structure that would allow the group to receive and distribute incentive payments; (2) include a sufficient number of primary care physicians regardless of specialty for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary); (3) report on required quality measures in the specified form, manner, and frequency; (4) report required data to monitor and evaluate the pilot program; (5) provide notice to applicable beneficiaries regarding the pilot program; (6) contribute to a best practices network or website to share strategies

on quality improvement, care coordination, and efficiency; (7) utilize patient-centered processes of care, and (8) meet other criteria determined to be appropriate by the Secretary.

Specific payment incentive models to be tested include: a performance target model, a partial capitation model, and other payment models.

Under the performance target model, a qualifying ACO would receive an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment would be made only if savings are greater than would result from normal variation in Medicare expenditures for Part A and B items and services. In general the Secretary would establish a base amount increased to the current year by an adjustment factor. The target may be established on a per capita basis. The base amount would equal the average total payments (or allowed charges) under parts A and B for applicable beneficiaries for whom the qualifying ACO furnishes items and services. The base amount may include Medicare Part D services if deemed appropriate. The adjustment factor would equal an annual per capita amount that reflects changes in expenditures from the base period to the current year. The factor could be determined as an amount or rate, determined on a national, regional, local or organization-specific basis, and may be determined on a per capita basis. It could also include an risk adjustment factor as determined by the Secretary. The base amount would be periodically recalculated.

A qualifying ACO that meets or exceeds annual quality and performance targets for a year would receive an incentive payment equal to an appropriate portion of the amount by which Medicare payments are estimated to be below the performance target. The Secretary could establish a cap on incentive payments for a year for a qualifying ACO. Incentive payments to qualifying ACOs would be limited to ensure that the aggregate expenditures do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program were not implemented.

The Secretary would be able to incorporate reporting requirements, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar physician payment initiatives under section 1848 of the SSA. Alternative criteria than would otherwise apply could be used when determining whether to make these payments so as to streamline administration of the overlapping monitoring and reporting requirements for ACOs and fee-for-service Medicare. Also, these incentive payments would not be included in the aggregate expenditure test described previously or in the performance target model.

Under the partial capitation model, a qualifying ACO would be at financial risk for some, but not all, of the part A and B items and services. The Secretary would be able to limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk. Payments under the partial capitation model would be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended if the pilot were not implemented. Partial

capitation would not constrain beneficiaries' to seeing any particular provider; beneficiaries would retain the ability to choose their doctor or practitioner and could leave the ACO at any time.

The Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency. Payments under these models would be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended if the pilot were not implemented.

An applicable beneficiary would be an individual who is enrolled under Part B and entitled to Part A benefits; is not enrolled in a Medicare Advantage plan under Part C or a PACE program under Section 1894 of the SSA; and meets other appropriate criteria.

The Secretary would monitor data on Medicare expenditures and quality of services after an applicable beneficiary discontinues receiving services through a qualifying ACO.

The pilot program would begin no later than January 1, 2012. An agreement with a qualifying ACO under this pilot would cover a multi-year period of between 3 and 5 years. The Secretary would be able to waive Medicare provisions and the general provisions established under Title XI of the SSA as necessary.

The Secretary would be required to report performance results to qualifying ACOs under the pilot program at least annually. There would be no administrative or judicial review of the (1) elements, parameters, scope, and duration of the pilot program; (2) the selection of qualifying ACOs for the pilot program; (3) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings; (4) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and (5) decisions about the extension of the program with successful ACOs, expansion of the program to additional ACOs or transitional extension of the existing physician group practice demonstration project.

Also, Chapter 35 of Title 44 of the United States Code (concerning the coordination of Federal information policy) would not apply to this pilot.

The Secretary would evaluate the payment incentive model for each qualifying ACO to assess the pilot's impact on beneficiaries, providers of services, suppliers and the program. The evaluation would be publicly available within 60 days of the date of completion of such report.

The OIG would be responsible for monitoring of the operation of ACOs under the pilot program with regard to violations of the Stark self referral prohibition (Section 1877 of the SSA).

No later than 2 years after the date the first pilot agreement is established, and every 2 years thereafter for 6 years, the Secretary would report to Congress on the use of authorities under the pilot program and its impact on expenditures, access, and quality. Subject to monitoring of the qualifying ACO, the Secretary would be able to extend the duration of the agreement if (1) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or (2) the ACO is consistently exceeding quality standards and is not increasing spending under the program. The Secretary would be able to terminate an agreement if the ACO did not receive in-

centive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

Subject to the evaluation of the pilot, the Secretary would be able to enter into agreements with additional qualifying ACOs to further test and refine payment incentive models. The Secretary would be able issue regulations to implement on a permanent basis 1 or more models of the pilot program that are beneficial to Medicare. However, to do so, the Chief Actuary of the CMS would be required to certify that the expansion of the program's components would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

The Secretary would be able to enter into an agreement with an organization participating in the physician group practice demonstration as a qualifying ACO. Participation as a qualifying ACO would be subject to rebasing and other appropriate modifications, until the pilot program under this section is operational.

The Secretary would be able to create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect natural variations in data availability, variation in average annual attributable expenditures, program integrity, and other matters the Secretary deems appropriate.

The Secretary would be able to limit a qualifying ACO's exposure to high cost patients in order to encourage the participation of smaller accountable care organizations in the pilot.

Nothing in this section would be construed as preventing qualifying ACOs participating in the pilot program from negotiating similar contracts with private payers. The Secretary would not be able to enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act, including health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

Nothing in this section would be construed to compel an organization to use an organization-specific target growth rate for an accountable care organization under this section for purposes of Medicare's physician fee schedule established under section 1848 of the SSA.

The program management account of CMS would be appropriated $25 million for FY2010 through FY2014 and $20 million in FY2015. The funds would be in addition to those otherwise appropriated and would be for the purposes of administering and carrying out the pilot program, but not for payments for Medicare covered items and services or for incentive payments.

Reason for Change

The Physician Group Practice (PGP) demonstration program has shown promise in incentivizing physicians and other providers to

reduce health care costs and improve quality. The ACO pilot program will build on progress that has been made to date in the PGP demonstration and gives CMS a flexible platform on which to continue to test, adjust and expand the shared savings concept.

Witnesses testified at an April hearing before the Committee that Medicare would be well served by rewarding providers who provide coordinated, efficient, high quality care by using the Accountable Care Organization shared savings model. Witnesses advised that by sharing a portion of spending reductions realized through efficient delivery of quality care, Medicare could move from simply paying physicians for the volume of care they provide toward paying for the value of care delivered. They expressed confidence that widespread use of ACOs, as facilitated by Medicare, would greatly improve the way care is organized and delivered throughout much of the health care system.

The ACO pilot program is designed to be flexible enough that a variety of physicians and other providers can participate. Many large, multispecialty group practices are well positioned to participate in the pilot program since most already provide integrated, coordinated care for their patients. The ACO pilot will recognize and reward efforts already underway by such groups, often in conjunction with hospitals, to provide efficient, high quality care. It will also allow providers to be rewarded for using advances in health information technology such as electronic medical records, telemedicine, and home monitoring equipment in ways that improve patient care. The Secretary should allow for the use of such technologies in order to facilitate coordinated, patient-centered care.

The Committee also recognizes that the majority of doctors in this country care for patients in practices of fewer than 10 physicians. The pilot is designed to allow physicians in small- and mid-sized practices to form an ACO without disrupting care for their patients. By joining together in ACOs, it is the Committee's hope that physicians in independent practices will better coordinate care and reduce the amount of duplicative care that is sometimes provided under the current payment system. The Committee recognizes that smaller practices face unique challenges in forming and sustaining ACOs, and urges the Secretary to use authority granted under the legislation to mitigate such challenges.

It is also the intent of the Committee that the Secretary should exercise flexibility in entering into participation agreements with a variety of ACO models to maximize the potential for innovation. The Committee believes that physicians, regardless of specialty, who play a central role in managing the care of their patient populations, and who are willing and able to be held accountable for the overall quality and costs of care for their patients across all care settings, should be allowed to form ACOs.

For example, the Secretary could permit the formation of ACOs that are principally composed of primary care physicians whose specialties are oncology, cardiology, nephrology, or other specialties that serve beneficiaries being treated for chronic conditions; physicians in the ACO would be held accountable for the overall quality and costs of care for beneficiaries, including care not directly related to the beneficiaries' principle diagnoses. The legislation also allows for physicians who are employed or otherwise affiliated with hospitals to form ACOs, as long as such physicians can be held ac-

countable for the preponderance of care furnished to a given patient population. The availability of such organizational models is especially important in regions where a large portion of physicians are employed by hospitals.

In addition to sharing savings that accrue to the Medicare program, physicians who participate in ACOs could have their own set of spending targets under the reformed physician payment update system in section 1121 of the legislation. This option is intended to give physicians an additional reason to form and join ACOs, and give providers within each ACO even more incentive to provide efficient, high-value care. Physicians who do so are likely to receive payments under the shared savings program and see regular positive updates to payment rates for physician services. It is the Committee's belief that this "virtuous cycle" has great potential to reduce the rate of spending growth in the Medicare program and result in better care for Medicare beneficiaries.

The Committee is aware that concerns have been raised about the possibility that providers in ACOs will attempt to meet the savings targets by selecting against beneficiaries that are more likely to require expensive care or under-provide needed care. No evidence of this behavior has been observed under the PGP demonstration, and the legislation calls for the use of risk adjusted spending targets and rigorous use of quality measures to mitigate such problems. Nevertheless, the Committee expects that the Secretary will take all appropriate steps to ensure that providers do not engage in activities that are contrary to the interest of Medicare beneficiaries. It is important to emphasize that providers are not required to take part in the ACO pilot program and providers who do participate must notify their patients.

Sec. 1302. Medical Home Pilot Program

Current Law

The Tax Relief and Health Care Act of 2006 (P.L. 109–432), as modified by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), requires the Secretary to establish a three-year demonstration in up to eight states with urban, rural and underserved areas, to redesign the health care delivery system to provide targeted, accessible, continuous, and coordinated family-centered care to high need Medicare populations with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment.

Proposed Law

A new section 1866E would be added to the SSA to establish the medical home pilot program for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services to high need beneficiaries in urban, rural, and underserved areas. New subsection 1866E(a) would require the Secretary to establish pilot programs to evaluate two medical home models: (1) the independent patient-centered medical home model; and (2) the community-based medical home model.

Subsection (b) of the new section would establish the following definitions. "Patient-centered medical home services" would be

those services that (1) provide beneficiaries with direct, ongoing access to primary care or principal care provided by a physician or nurse practitioner; (2) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings; (3) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified providers; (4) provide continuous access to care and communication with participating beneficiaries; (5) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, and coordination with community resources; (6) integrate readily accessible, clinically useful information into the care plans for participating patients; and (7) implement evidence-based guidelines, applying them to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries. "Primary care" would mean health care that is provided by a physician, nurse practitioner, or physician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine. "Principal care" would mean integrated, accessible health care provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions, and for whom the subspecialist assumes care management.

Subsection (c) of the new section establishes requirements for the independent patient-centered medical home pilot program. Under this program, the Secretary would be required to make payments for medical home services provided to targeted high need beneficiaries. An independent patient-centered medical home would be a physician-directed or nurse-practitioner-directed practice that is qualified to provide beneficiaries with patient-centered medical home services, and meets such other requirements as the Secretary may specify. A targeted high need beneficiary would be defined as a beneficiary who, based on a chronic disease risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

The Secretary would be required to determine an appropriate method to ensure that beneficiaries in the independent patient-centered medical home pilot program have agreed to participate. The program would have to begin within 6 months of enactment. The Secretary would be required to review alternative models for standard setting and qualification, and to establish a process to develop standards (1) to enable medical practices to qualify as patient-centered medical homes; and (2) to provide for the review and certification of medical practices as meeting such standards.

The Secretary would be required to establish a methodology for payment of services provided by independent patient-centered medical homes, and to adjust payments based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries. Moreover, the Secretary would be required to pay independent patient-centered medical homes a monthly fee, paid prospectively, for each targeted high need beneficiary who consents to receive services. In setting the fee amount, the Secretary would be required to: (1) consider the clinical work and practice expenses involved in providing the service (including services not currently reimbursable under Medicare, such as care coordination, population

disease management, and teaching self-care skills); (2) allow for differential monthly payments, depending on the capabilities of the independent patient-centered medical home; and (3) use appropriate risk-adjustment methods to ensure that higher payments are made for higher risk beneficiaries.

The independent patient-centered medical home pilot program would have to be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers. A physician in a group practice that participates in the Accountable Care Organization pilot program established in section 1866D of the SSA would not be eligible to participate in this pilot program, unless this program is ultimately made permanent.

Subsection (d) of the new section would establish requirements for the community-based medical home (CBMH) model pilot program. Under this program, the Secretary would be required to make payments to a CBMH for providing medical home services to a high need beneficiary. A CBMH would mean an appropriately qualified nonprofit community-based or State-based organization that provides beneficiaries with medical home services under the supervision of and in close collaboration with the primary care or principal care physician, nurse practitioner or physician assistant designated by the beneficiary as his or her CBMH provider. A CBMH would employ community health workers, including nurses or other non-physician practitioners, lay health workers, or other appropriate persons (as determined by the Secretary) that assist the primary or principal care physician or nurse practitioner in chronic care management activities, such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic conditions; or that help beneficiaries access health care or community-based services in their area. A CBMH would also have to meet other requirements as the Secretary may specify. In this section, the term "high need beneficiary" means an individual who requires regular medical monitoring, advising, or treatment.

The Secretary would be required to establish a process: (1) to determine the necessary qualifications for community-based or State-based organizations to function as CBMHs; and (2) to provide for the review and assessment of these qualifications pursuant to criteria to be established by the Secretary.

The Secretary would be required to start CBMH pilot program within 2 years of enactment. Demonstration sites under the pilot program would operate for up to 5 years after the initial implementation phase. In selecting sites, the Secretary would be authorized to give preference to (1) applications from geographic areas that propose to coordinate health care services for chronically ill beneficiaries across a variety of health care settings, practices with fewer than 10 physicians, rural health clinics, and federally qualified health centers; (2) payors that provide medical homes for chronically ill patients; or (3) States that propose to use the medical home model to coordinate health care services for individuals with chronic diseases who are enrolled under Medicare, Medicaid,

or fully dual-eligible for Medicare and Medicaid, across a variety of health care settings.

The Secretary would be required to establish a methodology for payment for medical home services furnished under the CBMH model, to include two separate prospective monthly payments for each high need beneficiary: one to a community-based or State-based organization, and one to the primary or principal care practice. In determining the amount of the payment, the Secretary would be required to consider the clinical work and practice expenses involved in providing the service (including services not currently reimbursable under Medicare, such as care coordination, population disease management, and teaching self-care skills); and to use appropriate risk-adjustment. The Secretary would be authorized to provide initial implementation funding to a community-based or State-based organization or a State participating in the CBMH pilot.

Subsection (e) of the new section would require the Secretary to evaluate the dual pilot program regarding (1) the extent to which medical homes result in a number of specified improvements in the quality and coordination of health care services delivered to complex patients, including reductions in health care expenditures; and (2) the feasibility and advisability of reimbursing medical homes for medical home services under Medicare on a permanent basis. The Secretary would be required, within 60 days of its completion, to publish and submit to Congress a report on the findings of such evaluation.

Subject to the results of the evaluation, the Secretary would be authorized to issue regulations to implement one or more models on a permanent basis, to the extent that such models are beneficial to Medicare, but only if the Chief Actuary of CMS were to first certify that the expansion would not result in higher estimated Medicare spending.

Subsection (f) of the new section would prohibit the Secretary from making payments under more than one model, or through more than one medical home under any model, for the furnishing of medical home services to an individual. Also, payments made under this pilot are in addition to, and have no effect on the amount of, payment for evaluation and management services made under this title. Chapter 35 of Title 44 of the U.S. Code (regarding federal information policy) would not apply to this section.

Subsection (g) of the new section would require the transfer of $6 million for each of fiscal years 2010 through 2014 from the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account, to carry out this section. In addition to funds otherwise available, $200 million for each of fiscal years 2010 through 2014 for payments for independent patient-centered medical home services, and $125 million for each of fiscal years 2012 through 2016 for CBMH services, would be available for CMS from the Federal Supplementary Medical Insurance Trust Fund. In addition to funds otherwise available, $2.5 million for each of fiscal years 2010 through 2012 would be available to CMS from the Federal Supplementary Medical Insurance Trust Fund for initial implementation costs. Any amounts made available under this subsection for a fiscal year would be available until expended.

Subsection (h) of the new section would provide that in addition to funds otherwise available for payment of medical home services, there would also be available, for the independent patient-centered medical home model, $100 million established by The Tax Relief and Health Care Act of 2006 (P.L. 109–432) for the existing Medicare Medical Home Demonstration, and authority for the Medicare Medical Home Demonstration project would be repealed.

Amendments made by this section would apply to services furnished on or after the date of enactment.

Reason for Change

Over 83 percent of Medicare beneficiaries have a chronic illness and over 95 percent of total spending in Medicare is linked to chronically ill patients. The medical home concept envisions a health care system where patient care is coordinated and integrated through a provider guided multidisciplinary team. The medical home model promotes accessible, continuous, patient-oriented, team-based and comprehensive care delivered in the context of a patient's family and community. The approach would manage care across a variety of settings according to the needs of the patient through the promotion of continuous care relationships as well as application of the chronic care model, use of evidence based-medicine, care coordination, and patient empowerment. The idea was described as early as 1967 by the American Academy of Pediatrics' Council on Pediatric Practice. The model has shown to be successful in improving outcomes for patients with chronic illnesses through improved care coordination. Many local pilot programs such as North Carolina's Community Care Program and Johns Hopkins' Guided Care Program have shown improved outcomes and potential for long term cost-savings. Vermont's Patient Centered Medical Home included payments to community entities for support of population-based health management.

Recent research has shown that patient populations at risk for health disparities may particularly benefit from the accessible, coordinated, comprehensive care delivered through the patient-centered medical home. Transforming practices serving high risk and chronically ill populations is a major focus of the revised and expanded pilot.

Systematic changes such as the use of evidence-based medicine and health-information technology offer new opportunities to achieve even better coordination, disease management, and patient empowerment. These goals would be achieved through practice transformation supported by new care-coordination payment models to the medical home to support the delivery of enhanced primary care services provided by a multidisciplinary team composed of care managers, pharmacists, physician assistants, mental health professionals, palliative care experts, clinical nurse educators, nutritionists or health educators.

This pilot program builds on the medical home approach currently being developed by Medicare and allows for a broader application of the medical home model to meet the needs of different patient populations and provider arrangements. It directs the Secretary to establish a "community-based medical home model" in addition to the "independent patient-centered medical home model" already under development. There are currently 25 active dem-

onstrations with payment reform in 17 States. This legislation will provide Medicare beneficiaries the ability to participate in locally based programs with an infrastructure that could facilitate practice transformation to become a medical home. Studies have indicated that such alternative models, that use community care teams within the medical home, can achieve cost savings and quality improvements. The independent patient-centered medical home model refers to the patient centered medical home demonstration program as legislated by MIPPA.

Regardless of what model is used, the pilot program requires that to be eligible the personal provider must provide accessible, continuous, coordinated and comprehensive care. In most cases, primary care providers would be best suited to the role of leading a multidisciplinary team to manage the care coordination, but specialists who can perform the medical home functions set forth by the Secretary are not precluded. In giving the Secretary flexibility in developing the monthly medical home care management fee payment, the Secretary can expand this program if certain criteria such as budget neutrality and quality improvements are met.

Effective Date

Date of enactment.

Sec. 1303. Payment Incentive for Selected Primary Care Services

Current Law

Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. In addition, for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments.

The bonus payment equals 10% of what would otherwise be paid under the fee schedule. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities

Proposed Law

The provision would establish payment incentives for primary care services furnished on or after January 1, 2011 by a primary care practitioner. The amount of the payment incentive would be 5 percent (or 10 percent if the practitioner provides the services predominately in an area that is designated as a primary care health professional shortage area) and would be paid from the Part B trust fund.

Primary care services would be defined as physicians' services in section 1848(j)(5)(A) as well as services furnished by another health care professional that would be described above if furnished by a physician. A primary care practitioner would be defined as (1) a physician or other health care practitioner (including a nurse practitioner) who specializes in family medicine, general internal medi-

cine, general pediatrics, geriatrics, or obstetrics and gynecology and has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed charges under (Medicare Part B) section 1848, as determined by the Secretary for the most recent period for which data are available, or (2) a physician assistant who is under the supervision of a practitioner described above.

There would be no administrative or judicial review respecting (1) any determination or designation of the primary care services payment incentive; (2) the identification of services as primary care services for the purpose of this payment incentive; or (3) the identification of a practitioner as a primary care practitioner for the purposes of this payment incentive.

The primary care services incentive payments would not be taken into account in determining the additional payments for physicians in health professions shortage areas or in physician scarcity areas. Furthermore, any bonus payment to physicians in health professions shortage areas or physician scarcity areas would not be taken into account in computing incentive payments for primary care services, nor would the primary care incentive payments be taken into account in determining the amounts that would otherwise be paid to physicians providing outpatient critical access hospital (CAH) services.

Reason for Change

Studies show that health systems emphasizing primary care have lower costs and better quality. Access to health insurance does not ensure access to timely medical care, particularly in places where doctors are in short supply like rural and inner-city urban areas. Currently, primary care accounts for about one third of the physician workforce, but far fewer U.S. medical students are pursuing careers in adult primary care than a decade ago. This provision is intended to encourage primary care providers who are currently practicing to remain in practice and incentivize additional physicians to choose a career in primary care. The provision also recognizes the challenges that certain areas of the country face in attracting a sufficient primary care workforce by providing an additional incentive to physicians who practice in health professional shortage areas.

Effective Date

January 1, 2011.

Sec. 1304. Increased Reimbursement Rate for Certified Nurse-Midwives

Current law

In general, Medicare pays 80% of the reasonable charges (the lesser of the actual charge for the services or the amount determined by the fee schedule) for provider services covered under Medicare Part B. However, Medicare payments for services performed by certified nurse-midwives to Medicare beneficiaries are currently limited to no more than 65% of the fee schedule amount for the same service performed by a physician.

Proposed Law

The proposal would remove the 65% restriction for Medicare payments to certified nurse-midwives. The modification would apply to services furnished on or after January 1, 2011.

Reason for Change

Nurse midwives are currently one of the lowest paid non-providers in Medicare. Yet, they practice independently and provide access to needed services in communities where gynecologists or obstetricians may not be readily available. In order to increase access to women's health services for Medicare beneficiaries, the provision increases the reimbursement for nurse midwife services from 65 percent of the fee schedule to 100 percent.

Effective Date

January 1, 2011.

Sec. 1305. Coverage and Waiver of Cost-Sharing for Preventive Services

Current law

In general, Medicare law authorizes the Secretary to cover services for the diagnosis and treatment of illness, while coverage of preventive services (i.e., services provided in the absence of illness) has generally required legislation. Section 1861 of the SSA requires coverage of a number of specified preventive services under Part B (often with specified conditions for coverage) in language interspersed throughout the section. There is no definition of "preventive services" in the law that refers to them collectively. Also, in Section 101 of the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110–275), Congress provided administrative authority for the Secretary to add coverage of new preventive services, under certain conditions.

Section 1833(a) of the SSA establishes coinsurance for the beneficiary, requiring Medicare to cover 80% of the costs of covered services under Part B, with specified exceptions. Section 1833(b) establishes an annual deductible for which the beneficiary is responsible. These sections have been amended over the years to waive coinsurance and/or the deductible for many, but not all, covered preventive services.

Proposed law

Subsection (a) of this section would add a new subsection to SSA Section 1861, which would define "Medicare covered preventive services" to mean a specified list of currently covered services. The list would also include any new services that were covered under the Secretary's administrative authority. Coverage would be subject to all conditions and limitations that apply to each listed service under current law.

With respect to Medicare covered preventive services (as defined by this bill), subsection (b) of this section would amend Section 1833(a) of the SSA to require Medicare to cover 100% of their costs. It would also amend several additional SSA sections to require the waiver of coinsurance for specified sigmoidoscopy and colonoscopy services, and, in outpatient hospital settings, for diagnostic mam-

mograms and Medicare clinical preventive services. This subsection would also amend Section 1833(b) of the SSA to waive the application of the deductible for Medicare covered preventive services. Finally, it would amend the SSA to remove the authority of providers to charge coinsurance when providing Medicare covered preventive services.

The amendments made by this section would apply to services furnished on or after January 1, 2011.

Reason for Change

Preventive benefits are vital to early detection and treatment of diseases, which can reduce the need for more serious treatments later.

However, utilization rates for Medicare's preventive benefits are very low. To help address that problem, the provision eliminates both the coinsurance and application of the deductible for preventive services. By eliminating all beneficiary cost-sharing for these services, more people should utilize the services.

Effective Date

January 1, 2011.

Sec. 1306. Waiver of Deductible for Colorectal Cancer Screening Tests Regardless of Coding, Subsequent Diagnosis, or Ancillary Tissue Removal

Current Law

Section 1833(a) of the SSA establishes coinsurance for the beneficiary, requiring Medicare to cover 80% of the costs of covered services under Part B, with specified exceptions. Section 1833(b) of the SSA requires the application of an annual deductible, for which the beneficiary is responsible, for some Part B services. Under current law, coinsurance is applied to colorectal cancer screening services, but the deductible is not.

Proposed Law

This section would amend Sections 1833(a) and 1833(b) of the SSA (as amended by Section 1305 of this bill) to clarify that coinsurance and the deductible would be waived for colorectal cancer screening services regardless of the code applied, of the establishment of a diagnosis, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test. This provision would apply to items and services furnished on or after January 1, 2011.

Reason for Change

Current law prohibits the application of the Medicare Part B deductible for screening colonscopies. However, if a patient has a screening colonscopy and the physician finds polyps that need to be removed during the screening exam, it is relabeled a diagnostic procedure and the deductible is applied. This policy is unfair to beneficiaries who are told that the screening colonscopy would bypass the deductible. This provision would therefore ensure that a screening colonscopy avoids the deductible and the coinsurance regardless of whether the procedure becomes diagnostic.

Effective Date

January 1, 2011.

Sec. 1307. Excluding Clinical Social Worker Services From Coverage Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment

Current Law

The majority of services provided to beneficiaries in a Medicare covered skilled nursing facility (SNF) stay are included in the bundled prospective payment made to the SNF. Certain services have been specifically excluded from SNF consolidated billing. In these instances, Medicare will pay the entity providing the service directly. Currently, the items and services provided by a clinical social worker are included in the SNF consolidated billing.

Proposed Law

Items and services provided by clinical social workers to Medicare beneficiaries in a SNF would receive separate Medicare payment on or after July 1, 2011.

Reason for Change

Numerous reports suggest that mental illness is highly prevalent in nursing homes, with mental health problems affecting more than 80% of the residents. These mental disorders including major depression, anxiety, and severe cognitive impairment or Alzheimer's disease interfere with a person's ability to carry out activities of daily living. Furthermore, older people have the highest rate of suicide of any age group, accounting for 20% of all suicide deaths. Clinical social workers are fundamental providers who facilitate care-planning and care-coordination. The provision treats clinical social workers identically to psychologists and psychiatrists with regard to their treatment of Medicare beneficiaries in nursing homes. Making this change will ensure better access to mental health services for Medicare beneficiaries in nursing homes.

Effective Date

July 1, 2010.

Sec. 1308. Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services

Current Law

Section 1861(s)(2) of the SSA (42 U.S.C. 1395x(s)(2)) defines services covered under the term "medical and other health services." These services include medical supplies, hospital services, diagnostic services, outpatient physical therapy services, rural health clinic services, home dialysis services and supplies, antigens and physician assistant and nurse practitioner services. Marriage and family therapists and mental health counselors are not included under current law.

Proposed Law

The proposal would add two subcategories of services to be covered under the term "medical and health services." These are (1) marriage and family therapists, and (2) mental health counselors.

The proposal would stipulate the required qualifications for a marriage and family therapist, and mental health counselor. It would define these providers' services as the diagnosis and treatment of mental illnesses, as permitted by his or her state license, if no other provider or facility is also paid for those services. The proposal would add a payment provision for marriage and family therapists, and mental health counselors. The amount paid would be 80% of the lesser of the actual charge for services or 75% of the amount that would be paid for a psychologist's services. The proposal would require the Secretary to consider confidentiality issues while developing criteria allowing for direct payment of the therapist and medical information sharing with the patient's primary care physician. The proposal would exclude marriage and family therapists and mental health counselors from the prospective payment system for skilled nursing facilities. The proposal would include marriage and family therapists and mental health counselors as providers in rural health clinics and federally qualified health centers. The proposed law would include marriage and family therapists and mental health counselors as one of the practitioner categories who can file claims for services provided.

Reason for Change

In states that have licensed or certified marriage and family therapists and mental health counselors, these practitioners provide mental health services to people under age 65. Few states did so when Medicare was first created in 1965. This provision updates Medicare coverage by allowing them to treat Medicare beneficiaries as well, subject to state law.

Sec. 1309. Extension of Physician Fee Schedule Mental Health Add-on

Current Law

By law, every five years CMS examines Medicare billing codes under the physician fee schedule to determine whether they are overvalued or undervalued. Subsequent to the most recent evaluation, Medicare increased the rates for the codes used by physicians to bill for "evaluation and management" (E/M) services (face-to-face visits with patients), effective January 1, 2007. To maintain budget neutrality, rates for certain other codes, including some used to bill for psychotherapy services, were reduced.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) increased Medicare payments under the fee schedule for psychotherapy services by 5% beginning on July 1, 2008, and ending on December 31, 2009. Psychiatric therapeutic procedures that involve insight oriented, behavior modifying, or supportive psychotherapy or interactive psychotherapy furnished in an office or other outpatient facility setting or in an inpatient hospital or residential care facility are reimbursed at this higher amount.

Proposed Law

This proposal would extend the increased payments provided by MIPPA for psychotherapy services for an additional two years (ending December 31, 2011).

Reason for Change

Studies reveal that between 15–25% of elderly people in the U.S. suffer from significant symptoms of mental illness. Of the direct costs for treating mental illness, less than 1.5% is spent on behalf of the elderly. The highest suicide rate in America is among those aged 65 and older. Access to mental health services is limited to Medicare beneficiaries in many areas. This provision is intended to provide mental health parity and increase much needed mental health services to the Medicare beneficiary.

Effective Date

January 1, 2011.

Sec. 1310. Expanding Access to Vaccines

Current Law

Medicare Part B covers influenza, pneumococcal, and, for individuals at increased risk, hepatitis B vaccinations. This coverage includes both the costs of these vaccines and their administration by recognized providers. Medicare Part D covers all vaccines licensed by the FDA, and their administration, when prescribed by recognized providers.

Proposed Law

Under this provision, Medicare Part B would cover all federally recommended vaccines, defined as any licensed vaccine that is recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention). The provision would also include all federally recommended vaccines in the suite of Medicare covered preventive services defined under section 1305 of this Act, and make several conforming amendments.

Reason for Change

Currently, a limited number of vaccines are covered by Medicare Part B while the rest are covered by Medicare Part D. This is confusing for beneficiaries and providers. For vaccines covered by Part D, beneficiaries may have to fill the vaccine prescription at a pharmacy and carry it with them to a physician's office for administration. This is burdensome for beneficiaries and providers alike and could lead beneficiaries to avoid getting needed immunizations. Moving coverage for all vaccines to Part B will simplify the vaccination process and improve access for beneficiaries.

Effective Date

January 1, 2010.

Sec. 1311. Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers

Current Law

SSA Section 1861(aa)(3) establishes that Federally qualified health centers may receive Medicare reimbursement for providing specified services, namely: diabetes outpatient self-management training services (DSMT); medical nutrition therapy (MNT) services; and preventive services that community health centers must provide under Section 330 of the Public Health Service Act (PHS Act). The latter services are: prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services.

Proposed Law

This provision would amend SSA Section 1861(aa)(3) to remove the reference to DSMT and MNT services, replacing it with a reference to the package of Medicare covered preventive services established in Section 1305 of this Act (which includes DSMT and MNT services, and others). The list of preventive services required under Section 330 of the PHS Act would continue to apply.

Reason for Change

Disease prevention plays a critical role in maintaining the health of Medicare beneficiaries and is also a core service delivered at Federally Qualified Health Centers (FQHCs). This provision would update the preventive benefits covered by Medicare in FQHCs to include the range of preventative services covered by the rest of the Medicare program.

Effective Date

Date of enactment.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Sec. 1401. Comparative Effectiveness Research

Current Law

The need for more and better information about which clinical strategies work best and under what conditions has been widely recognized by clinicians, patients, researchers and policy makers. Most recently, comparative effectiveness research was addressed in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) and the American Recovery and Reinvestment Act (ARRA, P.L. 111–5). Section 1013 of the MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research on the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services. In ARRA Congress provided $1.1 billion for comparative effectiveness research, with $400 million going to the

National Institutes of Health and $300 million to the Agency for Health Care Research and Quality to support comparative effectiveness research efforts at those agencies and $400 million to the Office of the Secretary to 1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

Proposed Law

The provision would establish a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality under title XI of the Social Security Act. The Center would conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

The duties of the Center would be to (1) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services, and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions; (2) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section; (3) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately; (4) submit to the Comparative Effectiveness Research Commission (see below), the Secretary, and Congress relevant reports produced by the Center or a grantee or contractor of the Center; and (5) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, postmarketing drug and medical device surveillance efforts, and other forms of electronic health data.

The Center could secure information necessary to enable it to carry out its duties directly from any department or agency of the United States. Upon request of the Center, the head of that department or agency would furnish the information to the Center on an agreed upon schedule. In order to carry out its functions, the Center would (i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements; (ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and (iii) adopt procedures allowing any interested party to submit information for the Center or the Commission to use in making reports and recommendations. The Comptroller General would have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission, immediately upon request, and both the Center and the Commission would be subject to periodic audit by the Comptroller General.

The Secretary would establish an independent Comparative Effectiveness Research Commission to oversee and evaluate the activities carried out by the Center to ensure that the Center's activities result in highly credible research and information produced from such research. The duties of the Commission would include the following:

(1) determine national priorities for research to be conducted, supported or synthesized by the center, and in making such determinations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

(2) monitor the appropriateness of use of the Comparative Effectiveness Research Trust Fund (CERTF) (described below) with respect to the timely production of comparative effectiveness research determined to be a national priority;

(3) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

(4) review the methodologies developed by the Center

(5) not later than one year after the date of the enactment, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences would conduct an evaluation and report on standards of evidence for such comparative effectiveness research;

(6) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

(7) make recommendations for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

(8) appoint a clinical perspective advisory panel for each national research priority, which would consult with patients and advise the Center on research questions, methods and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

(9) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center;

(10) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders; and

(11) make recommendations to the Center for the broad dissemination of the findings of research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value.

The members of the Commission would consist of the Director of the Agency for Healthcare Research and Quality, the Chief Medical Officer of the Centers for Medicare & Medicaid Services, and 15 additional members who would represent broad constituencies of stakeholders, including clinicians, patients, researchers, third-party payers, and consumers of federal and state beneficiary programs. At least 9 of the 17 members would be practicing physicians, health care practitioners, consumers, or patients. The members of the Commission would represent a broad range of perspectives and collectively would have experience in epidemiology, health services research, bioethics, decision sciences, health disparities, and economics. To ensure a diverse representation of the health care community, at least one member would represent each of the following: (1) patients, (2) health care consumers, (3) practicing physicians, including surgeons, (4) other health care practitioners engaged in clinical care, (5) employers, (6) public payers, (7) insurance plans, and (8) clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers. No more than 3 of the members of the Commission could be representatives of pharmaceutical or device manufacturers and these representatives could only be clinical researchers as described in (8).

The Secretary would appoint the members of the Commission; in considering candidates for appointment to the Commission, the Secretary could consult with the Government Accountability Office and the Institute of Medicine of the National Academy of Sciences. The Secretary would designate a member of the Commission, at the time of appointment, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Secretary could designate another member for the remainder of that member's term. The Chairman would serve as an ex officio member of the National Advisory Council of the Agency for Healthcare Research and Quality. Of the members first appointed, 8 would be appointed for a term of 4 years, and 7 would be appointed for a term of three years. Subsequently, each member of the Commission would be appointed for a term of four years.

To enhance effectiveness and coordination, the Secretary would be encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

The bill includes provisions to protect against potential conflicts of interest. In appointing the members of the Commission or a clinical perspective advisory panel, the Secretary or the Commission, respectively, would take into consideration any financial interest and develop a plan for managing any identified conflicts. When considering an appointment to the Commission or a clinical perspective advisory panel, the Secretary or the Commission would review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual would later require any pertinent waivers.

Prior to a meeting of the Commission or a clinical perspective advisory panel, each member of the Commission or the clinical perspective advisory panel who is a full-time government employee or

special government employee would disclose any relevant financial interests to the Secretary. A member of the Commission or a clinical perspective advisory panel could not participate with respect to a particular matter considered in a meeting of the Commission or the clinical perspective advisory panel if the member (or an immediate family member of the member) were to have a financial interest that could be affected by the advice given to the Secretary regarding the matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the government officers or employees to which such regulations apply. The Secretary could grant a waiver if the Secretary were to determine it necessary to afford the Commission or a clinical perspective advisory panel the essential expertise of the member. The waiver would permit such a member to participate as a voting or nonvoting member with respect to a particular matter under consideration in a Commission or a clinical perspective advisory panel meeting. The number of waivers granted to members of the Commission could not exceed one-half of the total number of members for the Commission. However, no voting member of any clinical perspective advisory panel would be in receipt of a waiver, and no more than two nonvoting members of any clinical perspective advisory panel would be serving under waiver. For purposes of determining conflict of interest under this section, the term "financial interest" would mean a financial interest under section 208(a) of title 18, United States Code.

While serving on the business of the Commission (including travel time), a member of the Commission would be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule, and while serving away from home and the member's regular place of business, a member could be allowed travel expenses, as authorized by the Director of the Commission.

The Commission would transmit a copy of each report submitted to the Secretary and would make the reports available to the public.

The Commission could (1) appoint an executive director (subject to the approval of the Secretary) and other personnel as Federal employees under section 2105 of title 5, United States Code as may be necessary to carry out its duties (without regard to the provisions of Title 5, United States Code, governing appointments in the competitive service); (2) seek assistance and support from appropriate federal departments and agencies as might be required in the performance of its duties; (3) enter into contracts or make other arrangements for the conduct of the work of the Commission, as may be necessary; (4) make advance payments, and other payments that relate to the work of the Commission; (5) provide transportation and subsistence for persons serving without compensation; and (6) prescribe such rules and regulations as it were to deem necessary with respect to the internal organization and operation of the Commission.

Any research conducted, supported, or synthesized by the Center would (1) be required to meet certain transparency, credibility and access conditions; (2) consider advice given by clinical perspective advisory panels; (3) consider stakeholder input; and (4) take into

account potential differences across subgroups of populations. To ensure transparency, credibility, and access, the research would meet the following conditions: (a) the establishment of the agenda and the conduct of the research would be insulated from inappropriate political or stakeholder influence; (b) the methods of conducting the research would be scientifically based; (c) all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research would be transparent to all stakeholders; (d) the process and methods for conducting such research would be publicly documented and available to all stakeholders; and (e) throughout the process of the research, the Center would provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

The research would meet a national research priority as determined above and would consider advice given to the Center by the clinical perspective advisory panel for the national research priority.

The Commission would consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission. Specifically, where deemed appropriate by the Commission, the consultation would include (1) recommending research priorities and questions, (2) recommending research methodologies, and (3) advising on and assisting with efforts to disseminate research findings. The Secretary would designate a patient ombudsman who would serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center and ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Commission.

Research falling under the activities of this Center would (1) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items and services used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), and individuals with different comorbidities; and (2) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

The proposal would require public access to comparative effectiveness information. Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report made by the Center, Commission, or clinical perspective advisory panel under this section, the appropriate information contained in the report would be posted on the official public Internet site of the Center and of the Commission, as applicable. For purposes of this section, a relevant report would be each of the following submitted by the Center or a grantee or contractor of the Center: (1) any interim progress report as deemed appropriate by the Secretary, (2) stakeholder comments, and (3) a final report.

To disseminate and assist in the incorporation of comparative effectiveness information, the Center would provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clin-

ical decision support, appropriate professional associations, and federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center would (1) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions; (2) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate; (3) include considerations such as limitations of research and what further research may be needed, as appropriate; (4) not include any data the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and (5) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

The Center would develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of the findings and the use and incorporation of the findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting the protocols and strategies, the Center would consult with stakeholders concerning the types of dissemination that would be most useful to the end users of information and could provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.

The provision would establish a number of reporting requirements. (1) Beginning not later than one year after the date of the enactment, the Director of the Agency of Healthcare Research and Quality and the Commission would submit an annual report on the activities of the Center and the Commission and research conducted under this section to Congress. Each report would include a discussion of the Center's compliance with the requirements for inclusion of subpopulations in research, including any reasons for lack of compliance. (2) Not later than December 31, 2011, the Secretary would submit to Congress an annual recommendation for a fair share per capita amount described below for purposes of funding the CERTF. (3) Not later than December 31, 2013, the Secretary, in consultation with the Commission, would submit to Congress a report on all activities conducted or supported under this section as of such date. The report would include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Commission but not funded.

The proposal would establish the Health Care Comparative Effectiveness Research Trust Fund ("CERTF") under the Internal Revenue Code (the "Code") to carry out the proposal's provisions relating to comparative effectiveness research. For fiscal year 2010 and in each subsequent fiscal year, amounts in the CERTF under section 9511 of the Internal Revenue Code of 1986 would be available to the Secretary to carry out this section without the need for further appropriations and without fiscal year limitation.

Nothing in this section would be construed to permit the Commission or the Center to mandate coverage, reimbursement, or other policies for any public or private payer.

For information regarding the establishment and financing the Comparative Effectiveness Research Trust Fund, see section 1802.

Reason for Change

All too often physicians and patients struggle to understand when a new drug, diagnostic test, surgical procedure or method of care delivery will be most helpful compared to the existing one, or how to choose among existing courses of treatment. This lack of clear information can create great confusion when it comes to difficult medical decisions. Health policy experts, researchers, consumers, and physician groups advocate that comparative effectiveness information (CER) is a needed public good and that greater investment in CER is critical to assuring high-quality care.

Better information about the relative strengths and weaknesses of various health care items, services and systems will help physicians and patients make more informed decisions regarding patient care.

Great variation exists in patient outcomes after a particular treatment. Currently, clinicians do not have evidence of these differences in patient outcomes or the effectiveness of different interventions for the same condition until after patients have been treated. Original research, systematic reviews, and synthesis of evidence must be designed, as appropriate, to take into account the potential for differences in effectiveness of health care items, services and systems with various subpopulations of patients such as racial and ethnic minorities, women, different age groups and individuals with different comorbidities. CER should not be viewed as one-size-fits-all medicine; rather, research should be designed to increase the amount and quality of evidence regarding what works, for whom, in what situation and why.

The dearth of knowledge about the comparative benefits of different interventions underscores the need for an objective entity to consider the evidence on all available interventions for a particular condition and their impact on different patient populations. Such an inquiry is a public good that could benefit all stakeholders and as such, there is a need for a sustained investment in comparative effectiveness research to improve the base of knowledge from which patients and physicians make important medical decisions.

To accomplish this sustained investment, the legislation establishes a Center at the Agency for Healthcare Research and Quality to conduct, support and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems and to aid in the dissemination of such research. The center will build on infrastructure and expertise already in place and work with public and private entities to conduct CER. The legislation also creates a public/private stakeholder commission to oversee the activities of the center, determine national priorities for research, appoint advisory panels for specific national priorities, review methodologies and standards of evidence for research, conduct outreach to stakeholders and make recommendations for the dissemination of research findings. In order to ensure the integrity of the research process, the commission and advisory

panels it appoints will be subject to strict conflict of interest requirements. These requirements are designed to ensure that the process for setting research priorities and evaluating research questions and methodologies will be free from inappropriate political and industry influence. Proper dissemination of research findings is an integral aspect of future investments in CER. The legislation reflects the importance of dissemination efforts to ensure that the research is comprehensible and useful to patients and providers in making health care decisions. In order to provide a consistent stream of public and private funding for CER through a mechanism insulated from outside influence, the legislation creates the Comparative Effectiveness Research Trust Fund (CERTF). The monies in the fund are derived from fees assessed to Medicare and private health insurance plans.

Effective Date

Date of enactment.

Subtitle B—Nursing Home Transparency

Part 1—Improving Transparency of Information on Skilled Nursing Facilities and Nursing Facilities

Sec. 1411. Required Disclosure of Ownership and Additional Disclosable Parties Information

Current Law

In general, Medicare and Medicaid require that skilled nursing facilities (SNF) and nursing facilities to be administered in a manner that maintains residents' well-being and safety. SNFs and nursing facilities are also required to report certain changes in ownership or controlling interest; in those individuals who are officers, directors, agents or managing employees; in the corporation, association or other company responsible for facility management; or when a change occurs in the SNF or nursing facility administrator position. SNFs and nursing facilities also are required to disclose ownership and other information as a condition of participation, and of certification or re-certification. In general, administrators must meet standards established by the Secretary.

Under Title XI of the Social Security Act, Section 1124, a person is considered to have an ownership or controlling interest, directly or indirectly, when (1) they own 5% or more of an entity, or they hold a whole or part of any mortgage, deed of trust, note or other obligation secured by the entity (nursing facility) or any property or assets that equal 5% of the total property; (2) are an officer or director of the entity, if the entity is organized as a corporation; or (3) are a partner in the entity if it is organized as a partnership. To a limited extent as determined feasible by the Secretary, nursing facility entities also are required to report other ownership and control interests for any persons named as owners or having a control interest.

Proposed Law

This provision would amend Section 1124 to require SNFs and nursing facilities to make available upon request by the Secretary, the Health and Human Services Office of the Inspector General

(OIG), the state where the entity is located, and the state long-term care ombudsman, information on ownership (including direct and indirect ownership), information on additional disclosable parties and information describing the governing body and organizational structure of the facility. SNFs and nursing facilities would be required to update disclosure information whenever changes occur. Information would need to be made available to the Secretary, OIG, the state where the entity is located, or the state long-term care ombudsman upon request until such time as this information became available publicly in accordance with final regulations promulgated by the Secretary. Facilities would not need to disclose and report vendors with which they do business on a routine basis that are independent third parties and do not have the ability to control the finances, operation, management or administration of a facility.

In addition, SNFs and nursing facilities would be required to post prominent notices in facility lobbies that ownership and additional disclosable party information are available upon request.

Facilities would be required to disclose the identity of and information on (1) each member of a facility's governing body including their name, title, date of start, and period of service for each SNF or nursing facility; (2) each person or entity who is an officer, director, member, partner, trustee, or managing employee, including their name, title, and period of service; (3) each person or entity who is an additional disclosable party; and (4) the organizational structure and relationship of the organizational entities to each SNF or nursing facility and each other for each ownership and governing individual or entity.

To the extent practicable, the Secretary may allow SNFs and nursing facilities in a manner specified by the Secretary to submit information using existing reporting mechanisms on ownership interest, governance, and organizational structure if they already report such information to other oversight agencies, such as to the Internal Revenue Service (IRS), using Form 990, the Securities and Exchange Commission, the Secretary, or through information otherwise submitted to any other federal agency.

Ownership or controlling interest would include direct or indirect interests through any number of intermediate entities and would include owners of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets, if the ownership interest is at least 5%.

Not later than two years after enactment, the Secretary would promulgate final regulations requiring SNFs and nursing facilities to report, in a standardized format, information about ownership, governing board, and organizational structure. The final regulations would require that as a condition of participation and payment, SNFs and nursing facilities certify that reported information is current and accurate. These regulations would take effect 90 days after the Secretary published the final regulations in the Federal Register.

The Secretary would provide technical assistance and guidance to states on how to adopt and implement the reporting requirements in the standardized format. This provision would not reduce, diminish, or alter any existing facility reporting requirements.

The following definitions would apply to this provision:

(1) "Additional disclosable party" would be any individual or entity who (a) exercises operational, financial, or managerial control over the facility or any part of the facility; (b) provides policies or procedures for any facility operations or provides financial or cash management services to the facility; (c) leases or subleases real property to the facility; or owns a whole or part interest of at least 5% of the total value of such real property; (d) lends funds or provides a financial guarantee to the facility of at least $50,000; (e) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

(2) The facility is defined as a "disclosing entity," which is a SNF operating under Medicare or a nursing facility operating under Medicaid.

(3) "Managing employees" include any employees, such as a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of a SNF or nursing facility's practices, finances, or operations.

(4) "Organizational structure" consists of the following: (a) the corporations, the officers, directors, and shareholders of corporations, who own at least 5% of the corporation; (b) the limited liability companies, the ownership interest of members and managers of limited liability companies (including the percentage owned by each member and manager); (c) the general partnerships, the general partners, the limited partnerships, the general and limited partners who own at least 10% of the partnership; (d) a trust, the trustees of the trust; (e) an individual, contact information for the individual; (f) and any other person or entity, as the Secretary determines appropriate.

Within one year of publication of the final regulations in the Federal Register, the Secretary shall make ownership disclosure and additional disclosable party information for SNF and nursing facilities available to the public as determined by the Secretary.

Reason for Change

Over the last 10 to 15 years, it has become clear that state and federal regulators are increasingly unable to effectively and quickly investigate complex webs of interlocking corporate relationships. When serious safety and quality problems become evident, sometimes in conjunction with financial irregularities, the response of regulators and law enforcement needs to be as swift as possible to protect the well-being of residents. However, under current law, regulators have increasingly encountered difficulties in identifying and holding accountable those persons and entities who are responsible for providing good resident care.

This is illustrated in a case recently settled by the HHS Office of Inspector General under the False Claims Act for serious quality of care deficiencies involving a facility in the District of Columbia. During the OIG's investigation, the nursing home fought hard to avoid disclosing both the intermediate companies linking the facility to its parent company, and the parent company itself. This information was not disclosed on the form that CMS requires to be submitted, and which informs the agency's database known as the

Provider Enrollment Chain and Ownership System, or PECOs. Even after an extensive investigation, the HHS OIG was still not able to uncover all of the multiple layers of limited liability companies and other structures that hid the true owners and operators—those who were calling the shots when it came to making decisions about the resources available for resident care.

State regulators have encountered similar problems. In 2008, the Connecticut Attorney General testified before the House Energy and Commerce Oversight and Investigations Subcommittee about a New England nursing home chain embroiled in a series of controversies and legal actions involving various allegations, including siphoning of Medicaid funds. The lack of transparency in the operations of the chain led to large legal expenditures by the State in order to try to identify the parties responsible for good resident care. Regrettably, issues of poor care and financial disarray continued even as investigators worked to try to identify those parties who should have been held accountable for providing good-quality services and overseeing proper management of fiscal resources, which include taxpayer funds, for those services.

Such situations highlight the need for making improvements in disclosure and reporting requirements. Current disclosure and reporting rules for nursing homes to divulge key ownership and non-ownership relationships with persons and entities that are in a position to control the resources and operations essential to good resident care are inadequate. This lack of transparency hinders the ability of regulators to enforce basic safety and quality standards, and obscures adequate disclosure about how public funds that are intended for resident care are actually being spent. The proposed provisions in Section 1411, which call for nursing homes to divulge those persons and entities that are in a position to make decisions about the operation, management and financing of services for resident care, will restore a measure of appropriate public accountability.

Effective Date

Date of enactment.

Sec. 1412. Accountability Requirements

Current Law

There are no comparable requirements in current law for SNFs and nursing facilities to implement compliance and ethics training programs for their employees.

Proposed Law

(1) Thirty-six months after enactment of this provision, SNFs and nursing facilities would be required to have complied with regulations developed by the Secretary governing the operation of compliance and ethics programs. The compliance and ethics programs would need to be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care. Operating organizations (entities that operate SNFs and nursing facilities) would be required to comply with the compliance and ethics programs regulations, including corporate-level management of multi-unit nursing home chains.

Within two years of the effective date of this provision, the. Secretary, in consultation with the HHS OIG, would promulgate regulations for effective compliance and ethics programs for operating organizations. These regulations may include a model compliance program, and would permit the design of the compliance and ethics programs to vary depending on an organization's size. Larger operating organizations would have more formal and rigorous programs with established written policies and procedures to guide employees. Regulations also would specifically address requirements for employees and managers of multi-nursing home chains.

Within three years after promulgation of final regulations, the Secretary would be required to evaluate the compliance and ethics programs and submit a report to Congress to determine if the compliance and ethics programs led to changes in deficiency citations, quality performance, or other patient care quality metrics. The Secretary's report to Congress would include recommendations to change the requirements of the compliance and ethics program, as the Secretary determined appropriate.

Compliance and ethics programs would need to be reasonably designed, implemented, and enforced to be generally effective in preventing and detecting civil, criminal, and administrative violations under the Social Security Act as well as in promoting quality of care, and would include the following required components:

(A) compliance standards and procedures that would guide employees and other agents and would reduce criminal, civil, and administrative violations.

(B) responsibility by senior individuals within operating organizations for overseeing compliance with the standards and procedures the entity establishes for their compliance and ethics program. These individuals would have resources and authority to assure compliance.

(C) diligence in ensuring that individuals who are at risk for engaging in criminal, civil, or administrative violations are not delegated responsibility for implementing or monitoring an organization's compliance and ethics program.

(D) effective communication of standards and procedures to employees (and other agents), through training programs or explanatory publications that practically illustrate what is required.

(E) assurance that the standards for their compliance and ethics programs are met by using procedures to detect criminal, civil, and administrative violations. Organizations can use procedures such as monitoring and auditing systems as well as installing a reporting system that enables employees (and other agents) to report violations by others without fear of retribution.

(F) appropriate disciplinary mechanisms that are consistently followed to enforce the compliance and ethics program standards. Operating organizations also must demonstrate that they have used, where appropriate, disciplinary measures for individuals failing to detect offenses.

(G) appropriate mechanisms to respond to detected offenses and strategies to prevent future similar offenses, including repayment of any funds to which an organization was not enti-

tled, and modification of compliance and ethics programs to detect criminal, civil, and administrative violations.

(H) periodic reassessment of their compliance and ethics program standards to ensure that the programs continue to be effective as the organization and facilities change.

(2) Before December 31, 2011, the Secretary would be required to establish and implement a quality assurance and performance improvement (QAPI) program. The QAPI program would include multi-unit chains. Under the QAPI program, the Secretary would establish facility standards and provide technical assistance to SNFs and nursing facilities on the development of best practices to meet the QAPI standards through regulation. Within one year after the Secretary promulgates such regulations—SNFs and nursing facilities would be required to submit plans to the Secretary describing how they will meet the QAPI standards and implement best practices.

(3) The Comptroller General of the Government Accountability Office (GAO) would be required to conduct a study that examined the following: (A) the extent to which corporations that operate large numbers of SNFs and nursing facilities are undercapitalized, taking into account ownership type (including private equity and control interests) are undercapitalized; (B) the effects of undercapitalization on quality of care, including staffing and food costs; and (C) options to address undercapitalization issues, such as requirements for surety bonds, liability insurance, or minimum capitalization. Within 18 months after this provision became effective, GAO would submit a report to Congress.

Reason for Change

For more than a decade, the HHS OIG and other Federal agencies charged with responsibility for enforcement of Federal law have emphasized the importance of compliance plans. In 1998, the OIG began offering guidance on the elements of a model compliance plan, noting in initial guidance for clinical labs that "compliance plans offer the health care provider an opportunity to participate in a nationwide effort to reduce fraud and abuse in our national health care programs."

Compliance program guidance for nursing homes was subsequently published in 2000, with supplemental guidance published in April 2008. In its supplemental guidance, the OIG observed that "a successful compliance program addresses the public and private sectors' common goals of reducing fraud and abuse, enhancing health care providers' operations, improving the quality of health care services, and reducing their overall cost. Meeting these goals benefits the nursing facility industry, the government, and residents alike. Compliance programs help nursing facilities fulfill their legal duty to provide quality care; to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs; and to avoid engaging in other illegal practices".

Yet not all nursing homes have voluntarily implemented compliance and ethics programs. The OIG believes that the incidence of fraud and abuse in the nursing home industry, which costs the government tens of millions of dollars annually, will decrease if all facilities are required to develop and implement effective internal

programs that aim to achieve better control of claims submissions, while also reducing the risk of criminal and civil liabilities.

Accordingly, and because the Federal government has a zero tolerance policy towards fraud and abuse, the proposed provisions in Section 1412 are designed to outline those elements of an effective and comprehensive compliance and ethics programs that nursing homes can use and adapt to fit the scale and scope of their operations.

In addition, this Section proposes that nursing homes develop Quality Assurance and Performance Improvement (QAPI) programs, which are vital for health care providers of all types. QAPI programs are designed to make health care organizations recognize and establish comprehensive systems that aim to deliver patient-centered care encompassing all individuals in an organization, from board to bedside, in an environment that promotes and demonstrates measurable improved outcomes for patients and families.

To achieve this, QAPI programs that have been developed to date involve a range of activities, including: setting expectations for patient safety; setting priorities for areas requiring improvement, and approving policies and procedures used to organize those efforts; collecting objective data to demonstrate actual improvements in care, safety, and prevention and reduction of medical errors; development of strategies for reviewing and acting on quality and safety indicators; and documentation of evidence that staff at all levels are involved in quality efforts.

Finally, Section 1412 asks the Government Accountability Office to undertake a study to shed light on reports that some nursing homes lack sufficient cash to carry on daily business at a level that is adequate for good patient care, which may in part be due to complex arrangements in which homes that are owned or operated by publicly or privately-held companies are stripped of assets to shield them from liability.

Sec. 1413. Nursing Home Compare Medicare Website

Current Law

There is no requirement in current law for Medicare's Nursing Home Compare website. The Nursing Home Compare website was developed by the Centers for Medicare and Medicaid Services (CMS) and launched in November 2002. The website was intended to bolster the agency's efforts to improve SNF and nursing facility quality of care and to make information on nursing home quality more accessible for long-term care consumers and their families. Since its launch, CMS has enhanced the website by adding or improving quality measures and website navigation. Medicare Nursing Home Compare includes national data on all nursing facilities that participate in Medicare and Medicaid. The data featured on Nursing Home Compare includes facility ratings, selected results from survey and certification inspections, and limited staffing information on SNFs and nursing facilities.

Proposed Law

The Secretary would ensure that the Nursing Home Compare website (or a successor website) contains additional information for SNFs and nursing facilities that is searchable and displayed in a

manner that is prominent, easily accessible, and clearly understandable for consumers, including:

(1) information on ownership and affiliated parties as would be required under Sec. 1411 above, Required Disclosure of Ownership and Affiliated Parties Information, that identifies SNF and SNF facility chains' ownership, governing boards, and organizational structure;

(2) information on CMS' Special Focus Facility facilities (or a successor program), including the names and locations of facilities that since the previous quarter that were, (a) newly enrolled in the program, (b) enrolled but failed to significantly improve, (c) enrolled and significantly improved, (d) graduated from the program, and (e) have closed voluntarily or been terminated by the Secretary;

(3) staffing data for each facility, including resident census, hours of care provided per resident per day, staff turnover, and tenure. These data would need to be displayed in formats that are clearly understandable to consumers and would permit them to compare staffing differences between facilities. This staffing information also would need to assist consumers in comparing an individual facility's staffing with state and national facility averages by providing: (a) concise explanations of how to interpret data (i.e., nursing home staff hours per resident day), (b) differences between staffing categories and, their associated training requirements, (c) the relationship between staff levels and quality of care, and (d) an explanation that residents with greater care needs can require greater staff levels or more staff training;

(4) links to state websites where state survey and certification program information can be found, including Form 2567 state inspection reports (or successor forms) and facility correction plans or other facility responses, along with information to guide consumers in interpreting and understanding survey and certification reports;

(5) the standardized complaint form developed by the Secretary under Sec. 1415 (below), which includes an explanation of how complaint forms are used and how to file a complaint with states' LTC ombudsman programs and survey and certification programs;

(6) summary information on the number, type, severity, and outcome of substantiated complaints; and

(7) the number of adjudicated criminal violations by the nursing facility or crimes committed by nursing facility employees (a) that were committed inside a facility; (b) for crimes or violations committed outside a facility, the instances where these were elder abuse, neglect, exploitation, criminal sexual abuse of an elder, or other violations that resulted in serious bodily injury; and (c) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

The Secretary is further directed to undertake a Nursing Home Compare review and modification process that would: (1) address the accuracy, clarity of presentation, timeliness, and comprehensiveness of the information reported on the website; and (2) within one year after the review's completion, a process to modify or re-

vamp the website in accordance with the Secretary's findings. In addition, this website review process would include consultation with the following organizations: (1) state LTC ombudsman programs, (2) consumer advocacy groups, (3) provider stakeholder groups, and (4) representatives of programs or groups the Secretary determines appropriate.

To improve the public's access to timely information on state survey and certification inspections, states would be required to submit information, including any enforcement actions, to the Secretary at the same time or before the state nursing home surveyors sent that information to facilities. Corrections to prior information submitted to the state also would need to be submitted to the Secretary in a timely manner. The Secretary is directed to update the Nursing Home Compare website with the information from states' survey and certification inspections as expeditiously as practicable, but at least quarterly. This requirement would be required within one year after this provision became effective.

The Secretary is also directed to conduct a Special Focus Facility program for enforcement of requirements for SNFs and nursing facilities that the Secretary identified as having substantially failed to meet applicable requirements of this provision. Under the Special Focus Facility program, the Secretary would conduct a survey of each facility in the program at least every six months.

Within one year of the effective date of this provision, SNFs and nursing facilities would be required to make available for any individual's review reports on surveys, certifications, and complaint investigations for the past three years and to post notices in prominent and accessible facility areas that these reports are available for inspection. These reports would need to exclude information identifying complainants or residents.

The Secretary would be required to provide guidance to states on how to establish Internet links to Form 2567 state inspection reports (or successor forms), complaint investigation reports, and facilities' correction plans or other responses to Form 2567. This information would be available on the state website for SNFs and nursing facilities. These reports also would be required to exclude information that identifies complainants or residents.

States would be required to maintain a consumer-oriented website that provided useful information on all SNF and nursing facilities operating within that state. The information on each facility would include Form 2567 state inspection reports (or successor forms), complaint investigation reports, facilities' plans of correction, and other information as determined useful by the Secretary or the state for consumers to use in assessing the quality of LTC options and the quality of care in individual facilities.

Reason for Change

The Federal website, Nursing Home Compare, is visited annually by tens of thousands of individuals looking for reliable, accurate information about a suitable facility for a loved one. While already a valuable resource, this website would greatly benefit from the addition of certain critical information—e.g., staffing levels in facilities based on real-time data; information about who the owners and affiliated business partners of nursing homes are; links to state websites where electronic copies of annual inspection reports

can be found; and information about any substantiated complaints filed against the facility, as well as criminal violations committed by staff.

Consumers would also benefit from the proposal in this Section that calls for states to develop clear information about the quality and safety of nursing homes as part of their websites, including explanations of how to interpret State inspection reports and plans of correction submitted by facilities when inspectors find deficiencies in quality and safety.

Effective Date

The modifications of Nursing Home Compare described in this section would become effective within one year of enactment, except that the Secretary would ensure that Ownership and Affiliated Parties, and Accountability Information as described in Sec. 1411, would be included on the website within one year of the date when those requirements were implemented.

Sec. 1414. Reporting of Expenditures

Current Law

There are no comparable provisions in current law that require SNFs or nursing facilities to report expenditures.

Proposed Law

Within one year of the effective date of this provision, the Secretary would consult with private sector accountants with knowledge of SNF cost reports to re-design cost report forms to separately capture wages and benefit expenditures for direct care staff.

Beginning with cost reports submitted three years after the effective date of this provision, SNFs would need to separately report direct care staff wages and benefits including (at least breaking out) (1) registered nurses, (2) licensed professional nurses, (3) certified nurse assistants, and (4) other medical and therapy staff.

Within 30 months (2½ years) of the effective date of this provision, the Secretary, in consultation with OIG, Medicare Payment Advisory Commission (MedPAC), and other experts identified by the Secretary, would categorize SNF's newly collected annual expenditure data for each facility, regardless of payment source, into the following functional accounts: spending on direct care services, including nursing, therapy, and medical services; spending on indirect care, including housekeeping and dietary services; capital assets, including building and land costs; and administrative services costs. The Secretary would establish procedures to make the expenditure data submitted under this provision, readily available to interested parties upon request, subject to requirements established by the Secretary.

Reason for Change

This provision would make it possible for policymakers and other interested parties to accurately determine and analyze how much funding a facility or chain dedicates to one of the most important aspects of resident care—staffing. Medicare cost reports do not currently capture this information, with the result that facilities may, if they wish, easily save money by making decisions to cut staff.

While research has established that staffing levels below a certain threshold are detrimental to good resident care, no consensus among policymakers has yet been achieved about the level of staffing that should be in place to assure good or optimal care. This new source of data on what facilities spend on staffing, in conjunction with Section 1416 below on reporting of staffing levels, would allow facilities to assess the amount of total funding that they dedicate to nurse aides with overall quality of care.

Sec. 1415. Standardized Complaint Form

Current Law

There are no provisions in current law requiring use of a standardized complaint form. Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. A range of statutorily defined sanctions is available to CMS and the states to help ensure that homes maintain compliance with federal quality requirements. CMS also is responsible for monitoring the adequacy of state survey activities.

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months. During a standard survey, separate teams of surveyors conduct a comprehensive assessment of federal quality-of-care and fire safety requirements. In contrast, complaint investigations generally focus on a specific allegation regarding resident care or safety.

The quality-of-care component of a survey focuses on determining whether (1) the care and services provided meet the assessed needs of the residents and (2) the home is providing adequate quality care, including preventing avoidable pressure sores, weight loss, and accidents. Nursing homes that participate in Medicare and Medicaid are required to periodically assess residents' care needs in 17 areas, such as mood and behavior, physical functioning, and skin conditions, in order to develop an appropriate plan of care. Such resident-assessment data are known as the minimum data set (MDS). To assess the care provided by SNF and nursing facilities, surveyors select a sample of residents and (1) review data derived from the residents' MDS assessments and medical records; (2) interview nursing home staff, residents, and family members; and (3) observe care provided to residents during the course of the survey. CMS establishes specific investigative protocols for state survey teams—generally consisting of RNs, social workers, dieticians, and other specialists—to use in conducting surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states.

Complaint investigations provide an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Complaints may be filed against a home by a resident, the resident's family, or a nursing home employee either verbally, via a complaint hotline, or in writing. Surveyors generally follow state

procedures when investigating complaints but must comply with certain federal guidelines and time frames. In cases involving resident abuse, such as pushing, slapping, beating, or otherwise assaulting a resident by individuals to whom their care has been entrusted, state survey agencies may notify state or local law enforcement agencies that can initiate criminal investigations. States must maintain a registry of qualified nurse aides, the primary caregivers in nursing homes, that includes any findings that an aide has been responsible for abuse, neglect, or theft of a resident's property. The inclusion of such a finding constitutes a ban on nursing home employment.

Proposed Law

The Secretary would be required to develop a standardized complaint form for SNF and nursing facility residents or their representatives to use in filing complaints on SNFs and nursing facilities to state survey and certification agencies and state LTC ombudsman programs. States would be required to make the new standardized complaint form available on request to SNF residents, people acting on behalf of residents, and employees or representatives of SNF and nursing facility employees.

States also would be required to establish a complaint resolution process that ensures that SNF and nursing facility residents, their representatives, or employees are not denied access to residents or retaliated against for complaining, in good faith, about quality of care or other issues in a facility, regardless of whether residents, their representatives or employees used the standardized form or some other method to submit their complaint. The state complaint resolution procedures would be required to include (a) procedures to ensure accurate tracking of complaints, (b) procedures to determine the likely severity of the complaint and procedures to investigate complaints, (c) deadlines for responding to complaints and procedures that would enable a complainant to track the complaint and investigation, and (d) procedures to ensure that the identity of complainants would be kept confidential.

The complaint resolution process would be required to include prohibitions against retaliation to ensure that SNF and nursing facility employees would not be penalized, discriminated, or retaliated against because they or anyone they requested to act on their behalf, in good faith, complained about the quality of care, services provided, or other issues related to quality of care or service in a nursing facility. This retaliatory prohibition applies regardless whether employees used the new standard or some other complaint method. In addition, retaliatory actions would not affect any aspect of complainants' employment, including discharge, promotion, compensation, terms, conditions, or employment privileges, or termination of a contract for services. SNFs would not be permitted to file complaints or reports with state professional disciplinary agencies against current or former employees because they (or their agents), acting in good faith, submitted complaints about quality of care or services in their employers' facility.

SNF and nursing facility employees who believed they were penalized, discriminated, or retaliated against, or lost service contracts because they submitted a quality-of-care complaint against a SNF, would be able to seek remedy in an appropriate U.S. district

court. U.S. district courts would have jurisdiction to grant complete relief, regardless of citizenship or amount in question, but not limited to injunction, such as reinstatement, compensatory damages (reimbursement of lost wages, compensation, and benefits), costs of litigation (including attorney's and expert witnesses' fees), exemplary damages, and other relief deemed proper by the court.

SNF and nursing facility employees' rights under this provision would not be diminished by contract or other agreement and would not diminish greater protection through other federal or state laws, contracts, or agreements. Nothing in this provision would prevent a resident, an agent acting on their behalf, or an employee from submitting a complaint in any manner and not necessarily by using the standardized complaint form. SNFs and nursing facilities would be required to conspicuously post in an appropriate location a sign as specified by the Secretary, that identifies employees' rights to bring complaints against the facility. Individuals would be considered to be acting in "good faith" when submitting complaints if they believe (1) their complaint is true, and (2) a violation has or may have occurred related to Medicare provisions of the Social Security Act. These amendments would apply one year after the effective date of this provision.

Reason for Change

Currently, there is inadequate documentation by the Federal government and by states of the number and type of complaints that residents and families file, the processes used to examine these complaints, and how and if they are resolved. Section 1415 is designed to address these flaws by requiring states to establish more standardized, uniform processes and procedures for handling and addressing complaints, and in so doing, to improve resident care. This Section also puts in place protections for nursing home employees who could—but who may in some instances today decide not to bring a serious quality or safety issue to the attention of supervisors or owners—for fear of facing discrimination, intimidation or threat of termination.

Sec. 1416. Ensuring Staffing Accountability

Current Law

There are no comparable provisions in current law for SNF and nursing facilities to report staff levels that are derived from payroll data in a uniform format.

Proposed Law

Within two years after enactment SNFs and nursing facilities would be required to electronically submit to the Secretary direct care staffing information, including agency and contract staff. In developing specifications and direct care staffing data requirements, the Secretary would consult with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties deemed appropriate by the Secretary. The direct care staffing specifications would be based on payroll and other verifiable data provided by SNFs and nursing facilities to the Secretary in a uniform format, and reporting on contract staff would be separate

from information on employees. Specifications would include (1) work categories of certified employees, including registered nurses, licensed practical nurses, licensed vocational nurses, certified nursing assistants, therapists, or other medical personnel; (2) resident census data and information on resident case mix; (3) an established reporting schedule; and (4) employee tenure and turnover, as well as hours of care provided by each certified employee category, per resident per day.

Reason for Change

Congress and the States have long debated the merits of instituting minimum staffing levels for nursing homes in order to provide a level of consistent care that cannot otherwise be maintained. However, such discussions have frequently been hampered by a lack of sound data on actual staffing levels in facilities across the country. By requiring CMS to develop an electronic system that facilities would use to report staffing data extracted from their payroll systems several times a year—and that is categorized to distinguish staff providing direct care from other types of work—Section 1416 will make it possible to more precisely quantify and analyze what level of staffing correlates to high-quality services. The information from Section 1414 above on what facilities spend on staffing, as compared to other types of costs, will further inform policymakers and facilities about the costs associated with providing optimal staffing in different types of facilities with varying case mix.

Part 2—Targeting Enforcement

Sec. 1421. Civil Money Penalties

Current Law

Under Medicaid law, states have authority either by regulation or law to impose money penalties, deny payments, appoint temporary management to bring facilities into compliance, and close facilities if nursing facilities fail to meet state plan requirements or have deficiencies that jeopardize residents' health or safety. State expenses for enforcement may be funded under the proper and efficient state plan administration provision of the Medicaid Statute (Title XIX of the Social Security Act). States also have authority to establish reward programs for nursing facilities that deliver the highest quality care to medical assistance patients and fund these incentive rewards programs under Medicaid's proper and efficient administration provisions.

Proposed Law

For SNFs and nursing facilities, the Secretary—and for nursing facilities, states—would have the authority to impose per instance or per day civil money penalties (CMPs) for each instance or each day of noncompliance (as determined appropriate by the Secretary). The amounts of the per instance CMPs would be the following: (1) in the case where a deficiency is the direct proximate cause of a resident's death, the penalty would not exceed $100,000; (2) in each case where a facility is cited for a resident's actual harm or immediate jeopardy, an amount equal to or greater than $3,050, but not more than $25,000; and (3) in each case of any other deficiency, penalty amounts per deficiency would range from not less than

$250 to not more than $3,050. The amount of the applicable per day CMPs would be the following: (1) an amount equal to or greater than $3,050 up to $25,000 where facilities were cited for deficiencies that caused actual harm or immediate jeopardy to residents; and (2) an amount between $250 and $3,050 for each case of any other deficiency.

Subject to limitations where reductions are prohibited if SNFs and nursing facilities self-report and promptly correct deficiencies within 10 calendar days after imposition of a CMP, the Secretary—or the state if applicable—may reduce the amount of the imposed CMP by up to 50%. The Secretary—or the state if applicable—would be prohibited from reducing CMPs for SNFs where the Secretary had previously reduced a penalty for that facility in the last year, with respect to a repeat deficiency. The Secretary—or the state if applicable—would be prohibited from reducing CMPs for other deficiencies: (1) where the deficiency was found to result in a pattern of harm or widespread harm that immediately jeopardizes residents' safety or health; or (2) where a deficiency resulted in the death of a patient.

Aggregate CMP reductions would not be permitted to exceed 35% on the basis of self-reporting, on the basis of a waiver or an appeal, or on the basis of both a waiver and an appeal. In collecting CMPs, the Secretary—or the state if applicable—must provide for the facility to participate in an independent informal dispute resolution process that generates a written record prior to penalty collection, and cannot impose additional per-day penalties during the pendency of the dispute resolution process; may provide an escrow account for fees to be held beginning on the earlier of 90 days after fees are imposed or the date the informal resolution process was completed; may provide that penalty fees are held in escrow accounts until appeals are resolved.

In situations where appeals are resolved in favor of facilities, the Secretary—or the state if applicable—may provide, if escrow accounts are established, that penalty fees would be returned to facilities with interest; and may provide, when facility appeals are unsuccessful, that some portion of penalty amounts are used to support state LTC ombudsman activities and to protect residents, including residents who reside in facilities that voluntarily or involuntarily close or are decertified.

The activities funded with CMPs may include using the penalty funds to offset costs of relocating residents to home- and community-based settings and other facilities, as well as projects to support resident and family councils and other consumer quality of care involvement (including joint training of staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

Provisions of the Social Security Act, Section 1128A (except subsections (a) and (b)) and provisions that require a hearing prior to imposing CMPs, also would apply to the CMPs described here.

The CMP amendments would apply one year after the effective date of the provision.

Reason for Change

Multiple reports issued by the Government Accountability Office have suggested that the penalties originally legislated as part of the 1987 Nursing Home Reform Act, and which took effect in 1994, may not be having a significant deterrent effect for several reasons. For example, a GAO report issued in December 2005, "Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety," noted that "state surveyors continue to understate serious deficiencies, as shown by the larger number of serious deficiencies identified in federal comparative surveys than in state surveys of the same homes."

Earlier GAO work found that the impact of monetary penalties was often weak due to large backlogs of appeals filed by providers. Those backlogs in turn had the effect of encouraging the federal government "to settle appealed cases, often reducing the size of the fine, and delay the imposition of the fine even if it is ultimately upheld after appeal. As a result," the agency's 1999 report concluded, "it is not surprising that some nursing home owners routinely appeal imposed penalties."

More recently, the HHS Office of Inspector General testified before the House Energy and Commerce Oversight and Investigations Subcommittee in May 2008 that CMPs "are an important element of an effective enforcement strategy, especially in cases when nursing homes are out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy," but also noted that "this tool has not been used to its full potential. For example, in an April 2005 report, OIG found that although $81.7 million in CMPs were imposed during 2000 and 2001, CMS had collected only $34.6 million (42 percent) by the end of 2002. We found that CMS did not utilize the full dollar range allowed for CMPs and that impositions were frequently at the lower end of the allowed ranges."

In addition, a 2009 analysis by the Center for Medicare Advocacy argued that fines for very serious deficiencies are too low to affect provider behavior. The Center's study of all federal administrative decisions issued in 2007 for nursing home enforcement cases found that the fines levied were low in relation to the harm suffered: For example, in one case, a fine of only $4,050 was assigned for the strangulation death of a resident on a bedrail. In response, the Center notes, some states have enacted laws with far higher penalties: California, for example, has a penalty of up to $100,000 for causing the death of a resident.

The provisions in this Section are designed to update and more effectively target CMP authority by focusing higher penalties only on serious quality of care and safety deficiencies that cause harm to residents, that put their health in immediate jeopardy, or that are life-threatening. Other modifications would allow facilities that self-report and promptly correct deficiencies to receive a reduction in their CMP of 50%. Finally, the Section aims to make collection of CMPs much more timely, by allowing the Federal government and States to collect fines following an initial independent dispute resolution process (IIDR) and to escrow these funds, pending the results of any further appeals.

To implement IIDR, the Secretary shall promulgate regulations pursuant to notice and comment rulemaking under the Administra-

tive Procedures Act. Such regulations shall allow IIDR to be conducted by an independent state agency (including an umbrella agency, such as the Health and Human Services Commission), a Quality Improvement Organization, or the state survey agency, so long as the participants in IIDR are not involved in the initial decision to cite the deficiency(ies) and impose the remedy(ies). Whoever is authorized to conduct IIDR must not have any conflicts of interest. The regulations may address the type of IIDR available to SNFs and NFs (desk review or in-person meeting) and the circumstances of each; may determine whether and when attorneys may represent the parties before IIDR; and may limit the duration of in-person meetings, depending on the scope and severity of deficiencies and other factors as determined by the Secretary.

As under current informal dispute resolution (IDR) processes, facilities may challenge only the factual basis of the deficiency. They may not challenge issues related to surveyors' compliance with the survey process or the scope and severity of the deficiencies. Also as under current IDR processes, states and the Secretary retain the right to reject the IIDR recommendations and to cite deficiencies and to impose remedies, as the states and the Secretary determine appropriate. Finally, as authorized by regulations governing informal review procedures of the Office of Surface Mining, 30 C.F.R. 723,18(b)(2), any person shall have the right to attend and participate in the conference.

Sec. 1422. National Independent Monitor Pilot Program

Current Law

No provision.

Proposed Law

Within one year of the effective date of this provision, the Secretary in consultation with CMG would establish a pilot program to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate SNF and nursing facility chains. The Secretary would select SNF and nursing facility chains to participate in a pilot independent monitor program from among those chains that apply to participate. The pilot independent monitor program would be conducted over two years. The pilot independent monitor program would commence within one year of the effective date of this provision.

The Secretary shall evaluate a chain to participate in the pilot program based on criteria selected by the Secretary, including chains with one or more facilities in CMS' Special Focus Facility program (or a successor program) or one or more facilities with a record of repeated serious safety and quality of care deficiencies.

An independent monitor that enters into a contract to participate in the pilot program would have the following responsibilities: conduct periodic reviews and root-cause deficiency analyses of chains to assess their compliance with state and federal laws and regulations; sustained oversight of chains (whether public or private) to involve chain owners and principal partners in facilitating compliance with state and federal laws and regulations applicable to facilities; analyze management structure, expenditure distribution, and nurse staff levels of facilities of the chain compared to resident

census, staff turnover rates, and tenure; report findings and recommendations with respect to reviews, analyses, and oversight to the chain and facilities in the chain, to the Secretary and to relevant states; and publish the results of these reviews, analyses, and oversight.

Within 10 days of a chain receiving a finding (of deficiency) from the independent monitor, the chain would be required submit a report to the independent monitor (1) that outlines corrective actions the chain will take to address the independent monitor's recommendations or (2) indicates that the chain will not implement the recommendations and why it will not do so.

Within 10 days after receiving the chain's response-report, the independent monitor would be required to submit a report containing the monitor's final recommendations to: the chain, the chain's facilities, the Secretary, and the state or states where the facilities in question operate.

The chain would be responsible for a portion of the costs associated with the appointment of the pilot program independent monitors. The chain would pay their portion of the costs to the Secretary. The Secretary would determine the amount and procedures for collecting the independent pilot program costs. The Secretary would have authority to waive provisions of the Medicare and Medicaid statutes (Titles XVIII and XIX of the Social Security Act) if necessary to implement the independent monitor pilot program. Appropriations necessary to carry out the independent monitor pilot program would be authorized.

The OIG would evaluate the independent monitor program within six months of completion of the program. The OIG would submit a report to Congress on the independent monitor program that included recommendations for legislative and administrative action.

Reason for Change

Promising work pioneered by the HHS OIG in the context of agreements with nursing home chains that have chronic, severe quality and safety problems, and which agree to a system of close monitoring by independent contractors with expertise to undertake "root cause analyses" provide a model for CMS, as the principal regulatory agency, to develop a similar mechanism of oversight.

Sec. 1423. Notification of Facility Closure

Current Law

Medicare and Medicaid law identifies patients' rights and SNF and nursing home requirements in ensuring residents are aware of their rights. Residents have specific discharge and transfer rights, which include advance notification in cases where facilities close.

Proposed Law

SNF and nursing facility administrators would be required to issue written notification of intent to close to the Secretary, LTC Ombudsman programs in the state where facilities are located, facility residents, and facility residents' legal representatives or other responsible parties. SNF and nursing facility administrators would need to provide 60 days' notice of their pending closure or, if closed by the Secretary, within the time frame specified by the Secretary.

SNF and nursing facility administrators would be required not to admit new patients on or after written notice of planned closure; and to include in the closure notices the plans to transfer and adequately relocate facility residents by a specified date prior to closure that has been approved by the state, and which also would include assurances that residents will be transferred to the most appropriate facilities or settings in terms of quality, services, and location as determined by residents' needs, best interests, and preferences.

The state would ensure that before SNFs and nursing facilities close, all residents would be relocated to alternative settings, such as home- and community-based settings or other facilities, taking into consideration the needs and best interests of each resident. The Secretary may determine the appropriate payment and whether and for how long to continue payments to closing facilities during the period after the notification of impending closure is submitted and the date when residents are transferred to other facilities or alternative settings.

Reason for Change

When nursing homes close, residents and their families are left to quickly find an alternative setting for care, a task that can be challenging under a tight timeframe and if there is limited availability or variable quality in neighboring institutions. This provision ensures that residents and their families have proper advance notice of a closure, and that residents are relocated prior to closure. The Committee recognizes the importance of making sure that the needs and best interests of each resident are taken into account during the relocation process.

Effective Date

One year after the date of enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

Sec. 1431. Dementia and Abuse Prevention Training

Current Law

Under Medicare law, the Secretary establishes SNF requirements for nurse aide training and competency evaluation programs and requirements for states to follow in evaluating and reevaluating these training programs. Similarly under Medicaid law, the Secretary establishes nursing facility requirements for nurse aide training and competency evaluation programs and requirements for states to follow in evaluating and re-evaluating these training programs.

Proposed Law

This provision would add dementia and abuse prevention training to staff training requirements for SNF and nursing facilities. The Secretary would revise initial nurse aide training, competency, and evaluation program requirements to include dementia management and patient abuse prevention training. If determined to be appropriate, the Secretary also may include dementia management training and patient abuse prevention in ongoing nurse aide training, competency, and evaluation program requirements.

Reason for Change

It has been reported that the majority of older nursing home residents have some form of psychiatric illness, with dementia affecting 1 out of 5 residents. Timely recognition and intervention are key to the optimal care of older adults with dementia, which may be attributable to a number of causes. Additionally, the frail elderly are some of the most vulnerable members of our society particularly when patients have co-morbid conditions that will prohibit them from articulating maltreatment by others. This provision will direct the Secretary to include dementia and abuse prevention training of nursing home staff.

Effective Date

One year after the date of enactment of this Act.

Sec. 1432. Study and Report on Training Required for Certified Nurse Aides and Supervisory Staff

Current Law

Medicare and Medicaid law have provisions that govern training for nurse aides for both SNF and nursing facilities. These laws require the Secretary to establish requirements for nurse aide training and competency evaluation programs as well as parameters for states to use in monitoring these programs.

Proposed Law

The Secretary would be required to conduct a study within two years of the effective date of this provision on the content of certified nurse aide and supervisory staff training in SNFs and nursing facilities. The report shall include the following: whether the 75 hours of initial nurse aide training required should be increased and if so, what the required number of recommended initial training hours should be (including dementia related training); and whether the 12 hours per year of ongoing nurse aide training should be increased and what content changes are recommended. In assessing the number of hours of initial nurse aide training required, the Secretary would consult with states that already have increased the number of hours of initial training above 75 hours. Within two years from the effective date of this provision, the Secretary would be required to submit a report to Congress on the certified nurse aide and supervisory training requirements. The report would include recommendations for legislative and administrative action.

Reason for Change

Certified Nurse Aides and supervisory staff are some of the primary caregivers in a skilled nursing facility. It is important to know whether existing training requirements are sufficient to ensure appropriate care for the patient population in these facilities.

Subtitle C—Quality Measurements

Sec. 1441. Establishment of National Priorities for Quality Improvement

Current Law

There are no provisions in current law that require the development of national priorities for performance improvement (directed either at the Secretary of Health and Human Services or the Agency for Healthcare Research and Quality).

However, Section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress.

The National Quality Forum has been awarded this contract and recently released its first report, Improving Healthcare Performance: *Setting Priorities and Enhancing Measurement Capacity,* in fulfillment of this statutory requirement.

Proposed Law

This provision would amend Title XI of the Social Security Act, as amended by section 1401(a), by adding a new Part E- Quality Improvement- Establishment of National Priorities for Performance Improvement. Specifically, it would add a new section 1191 to establish national priorities for performance improvement.

This Section would require the Secretary to establish and periodically update (not less frequently than triennially) national priorities for performance improvement. Specifically, it would require the Secretary, when establishing and updating national priorities, to solicit and consider recommendations from multiple outside stakeholders.

This provision would require, with respect to the national priorities for performance improvement, the Secretary to give priority to areas in the delivery of health care services that (1) address a large burden of disease, as specified; (2) have the greatest potential to decrease morbidity and mortality in the United States, as specified; (3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care; (4) address health disparities across groups and areas; and (5) have the potential for rapid improvement due to existing evidence or standards of care.

For the purposes of this Section: (1) consensus-based entity would mean an entity with a contract with the Secretary under Section 1890 of the Social Security Act; and (2) quality measure would mean a national consensus standard for measuring the performance and improvement of population health, or of institutional

providers of services, physicians, and other health care practitioners in the delivery of health care services.

This provision would require the Secretary to provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, of $2 million for each of the fiscal years 2010 through 2014. It would also authorize the appropriation of $2 million for each of the fiscal years 2010 through 2014 from any funds in the Treasury not already appropriated.

Reason for Change

Currently, there is no coordinated effort at the national level for prioritizing efforts to improve performance of the care delivery system or to measure those efforts. Section 1890 of the Social Security Act establishes a process to prioritize performance improvement and measurement within the Medicare program. This provision would expand and build on those efforts by establishing priorities for health performance improvement at the national level. It is the Committee's intent that the priorities established by the Secretary will have wide applicability and help direct health improvement activities across the nation's health care system.

Effective Date

Date of enactment.

Sec. 1442. Development of New Quality Measures; GAO Evaluation of Data Collection Process for Quality Measurement

Current Law

Section 1110(a)(1) of Title XI of the Social Security Act provides general authority to appropriate such sums as may be necessary for making grants to States and public and other organizations and agencies for research that will help improve the administration and effectiveness of the programs carried out under the Social Security Act, among other things.

The Agency for Healthcare Research and Quality (AHRQ) has significant existing statutory authorities with respect to the development of quality measures. Specifically, the Agency's mission, among other things, is to promote health care quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality (Sec. 901 of the PHSA).

Section 912 of the PHSA requires AHRQ to provide support for public and private efforts to improve health care quality, and that the role of the Agency shall specifically include the ongoing development, testing, and dissemination of quality measures, including Measures of health and functional outcomes and the compilation and dissemination of health care quality measures developed in the private and public sector. To comply with this last requirement, the Agency has established the National Quality Measures Clearinghouse, an online resource that compiles and catalogues quality measures.

Finally, Section 917 of the PHSA requires AHRQ to coordinate all research, evaluations, and demonstrations related to health

services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

Proposed Law

This section would amend Part E of Title XI of the Social Security Act, as added by section 1441, by adding two new sections: Section 1192: development of new quality measures and Section 1193: GAO evaluation of data collection process for quality measurement.

Section 1192

This Section would require the Secretary to enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States. The Secretary would be authorized to carry out these agreements by contract, grant, or otherwise. In addition, this Section would require the Secretary to seek public input and take into consideration recommendations of the consensus-based entity with a contract with the Secretary under Section 1890(a) of the Social Security Act. The Secretary would be required, as specified, to determine areas in which quality measures for assessing health care services in the United States are needed.

Quality measures developed under these agreements would be required to be designed (1) to assess outcomes and functional status of patients; (2) to assess the continuity and coordination of care and care transitions, as specified; (3) to assess patient experience and patient engagement; (4) to assess the safety, effectiveness, and timeliness of care; (5) to assess health disparities as specified; (6) to assess the efficiency and resource use in the provision of care; (7) to the extent feasible, to be collected as part of health information technologies supporting better delivery of health care services; (8) to be available free of charge to users for the use of such measures; and (9) to assess delivery of health care service to individuals regardless of age.

This provision would also require the Secretary to make proposed quality measures available to the public; would authorize the Secretary to use amounts made available under this Section to fund the testing of proposed quality measures by qualified entities, as specified; and would authorize the Secretary to use amounts made available under this Section to fund the updating, by consensus-based entities, of quality measures that have been previously endorsed by such an entity as new evidence is developed (consistent with Section 1890(b)(3) of the Social Security Act).

Grants would be authorized to be made under this Section only if an application for the grant would be submitted to the Secretary as specified and the Secretary would be required to ensure, before entering into agreements with qualified entities, that the entity is a public, nonprofit or academic institution with technical expertise in the area of health quality measurement.

For purposes of carrying out this section, the Secretary would be required to provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, of $25 million each year from fiscal years 2010 through 2014. In addition, this section would authorize the appropriation of $25 million for each of the fiscal years 2010 through 2014 from any funds in the Treasury not otherwise appropriated.

Section 1193

This Section would require the Comptroller General of the United States to conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

It would require the Comptroller General to determine: (1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible; (2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients' personal health information and provides data security; (3) whether standards under the system provide for an opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and (4) the extent to which quality measures are consistent with requirements for quality measures developed under this Act, as specified, or result in direct or indirect costs to users of such measures.

This section would require the Comptroller General to report to Congress and to the Secretary on the findings and conclusions of the results of each such evaluation.

Reason for Change

Robust, accurate, and appropriate measures of health care quality are a critical component of improving the delivery system and health outcomes. It is difficult to develop and implement strategies to improve patient health without such measures, but in many cases measures do not exist or have yet to be fully developed. In other cases, measures do exist but need to be updated or modernized. Putting additional resources into quality measure development will speed the development of new measures and address shortcomings of existing measures. The requirement that the Comptroller General monitor the development and application of health quality measures will help ensure that such measures are being used properly.

Effective Date

Date of enactment.

Sec. 1443. Multi-Stakeholder Pre-Rulemaking Input Into Selection of Quality Measures

Current Law

No provision.

Proposed Law

This section would amend section 1808 of the Social Security Act by adding a new subsection (d): Multi-Stakeholder Pre-Rulemaking Input into Selection of Quality Measures.

The new subsection would require the Secretary, not later than December 1 before each year (beginning with 2011), to publish a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under Title XVIII of the Social Security Act, as specified. This

section would also require the consensus-based entity that has entered into a contract under section 1890 of the Social Security Act to convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in public reporting of performance information or in public health care programs. The section would also require the consensus-based entity, not later than February 1 of each year (beginning with 2011), to transmit to the Secretary the recommendations of these multi-stakeholder groups, as specified.

This section would require the consensus-based entity, in convening multi-stakeholder groups, to provide for an open and transparent process for the activities conducted pursuant to such convening. This process would have to ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection. This section would require the respective proposed rule to contain a summary of the recommendations made by the multi-stakeholder groups under this section, as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

The provision would define the term "multi-stakeholder groups" to mean, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following: (1) hospitals and other institutional providers; (2) physicians; (3) health care quality alliances; (4) nurses and other health care practitioners; (5) health plans; (6) patient advocates and consumer groups; (7) employers; (8) public and private purchasers of health care items and services; (9) labor organizations; (10) relevant departments or agencies of the United States; (11) biopharmaceutical companies and manufacturers of medical devices; (12) licensing, credentialing, and accrediting bodies.

For purposes of carrying out this section, the Secretary would be required to provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund under, of $1 million each year from fiscal years 2010 through 2014. In addition, this section would authorize the appropriation of $1 million for each of the fiscal years 2010 through 2014 from any funds in the Treasury not otherwise appropriated.

Reason for Change

The Medicare program is increasingly making use of health care quality measures in administration of its payment systems. As the program continues to evolve, the Committee expects this trend will continue and that a larger portion of provider payments will eventually become linked to performance on such measures. For instance, the Accountable Care Organization pilot program in section 1301 of this legislation will make extensive use of quality measures.

Given the greater reliance on quality measures within Medicare, the process for selecting such measures should be an open and collaborative one. This section provides the Medicare program with a process for engaging with a wide array of stakeholders and interested parties, including patient advocacy organizations, employers,

private purchasers, and providers. Such engagement will help ensure that Medicare selects the most appropriate measures for each of its payment systems and promote consistent use of measures among other stakeholders.

Effective Date

Date of enactment.

Sec. 1444. Application of Quality Measures

Current Law

Section 1886(b)(3)(B)(vii) of the Social Security Act requires hospitals to submit specified quality data to the Secretary in order to receive a full annual payment update. Section 1886(b)(3)(B)(viii)(V) provides that beginning with payments in fiscal year 2008, the Secretary shall add additional quality measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

Section 1833(t)(17)(A)(i) of the Social Security Act requires hospitals to submit data on outpatient quality measures to the Secretary in order to receive a full outpatient department (OPD) fee schedule increase. In addition, section 1833(t)(17)(C)(i) requires the Secretary to 302 develop measures that reflect consensus among affected parties, and to the extent feasible and practicable, to include measures set forth by one or more national consensus building entities.

Section 1848(k) of the Social Security Act requires the Secretary to implement a system for the reporting by eligible professionals of data on specified quality measures. Section 1848(k)(2)(C)(i) requires that for 2010 and subsequent years, the quality measures specified under this section will be such measures selected by the Secretary from measures that have been endorsed by the consensus-based entity with a contract under section 1890(a) of the Social Security Act. Section 1848(k)(2)(C)(ii) provides an exception in the case of a specified area or medical topic for which feasible and practical measures have not been endorsed, stipulating that such measures may be used as long as due consideration has been given to measures that have been endorsed or adopted by a consensus organization.

Section 1881(h)(1) of the Social Security Act requires renal dialysis facilities to meet (or exceed) a total performance score, based on quality measures as specified, in order to receive full payment for services furnished on or after January 1, 2012. In addition, section 1881(h)(2)(B) requires the Secretary to specify measures that have been endorsed by the consensus-based entity with a contract under section 1890(a), and authorizes the Secretary, where endorsed measures are not available, to use such measures provided that due consideration has been given to measures that have been endorsed or adopted by a consensus organization.

Section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, to perform certain duties. Included in these, at section 1890(b)(2) of the Social Security Act, is a requirement that the consensus-based entity provide for the

endorsement of standardized health care performance measures, as specified.

Proposed Law

Generally, this section places requirements on the Secretary when selecting quality measures for use in existing quality programs for inpatient, outpatient, physician and renal dialysis services. These requirements relate to the endorsement of quality measures.

Specifically, this section would amend section 1886(b)(3)(B) of the Social Security Act to require the Secretary to select measures for purposes of reporting data for inpatient hospital services furnished during fiscal year 2012 and each subsequent year, that have been endorsed by the consensus-based entity with a contract with the Secretary under section 1890 of the Social Security Act. If feasible and practical measures were not available, the Secretary would be authorized to select a non-endorsed measure, providing the Secretary gives due consideration to endorsed or adopted measures. The Secretary would be required to submit non-endorsed measures to the entity for consideration for endorsement, and if the entity were to not endorse the measure, and the Secretary were to continue to use the measure, the Secretary would be required to include the rationale for its continued use in rulemaking. This section would also amend section 1833(t)(17) of the Social Security Act to require that the provisions added to section 1886 (above) would also apply to quality measures for covered outpatient department services.

This section would also amend sections 1848(k)(2)(C)(ii) and 1881(h)(2)(B)(ii) of the Social Security Act, to require the Secretary to submit non-endorsed measures for physicians' services and renal dialysis services, respectively, to the consensus-based entity for consideration for endorsement. It would further require the Secretary, if the measure does not gain endorsement and if the Secretary continues to use the measure, to provide a rationale for continued use in rulemaking.

This section would, by amending section 1890(b)(2) of the Social Security Act, require the consensus-based entity with a contract with the Secretary in section 1890 to explain the reasons underlying non-endorsement of a given measure, and to provide suggestions about changes to such measure that might make such a measure potentially endorsable.

This section would apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.

Reason for Change

To the extent feasible, the Medicare program should use measures of health quality that have been endorsed by a consensus-based organization, such as the National Quality Forum. The use of endorsed measures will help ensure that Medicare is utilizing the most appropriate and robust measures, while also using measures that have widespread support among various health care stakeholders. However, the Committee recognizes it is critical that the Medicare program maintain its independence and retain the flexibility to use non-endorsed measures when it deems necessary.

Effective Date

Date of enactment.

Sec. 1445. Consensus-Based Entity Funding

Current Law

Section 1890 of the Social Security Act requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Foram, to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress.

Section 1890(d) of the Social Security Act provides for $10 million to fund the activities of the consensus-based entity under contract in this section for each of fiscal years 2009 through 2012.

Proposed Law

This section would amend section 1890(d) of the Social Security Act to provide for $10 million only for fiscal year 2009, and $12 million for each of the fiscal years 2010 through 2012.

Reason for Change

This provision is needed to provide funding available under CMS's current contract with the National Quality Forum to cover additional expenses related to implementation of section 1441 of this legislation, regarding multi-stakeholder input on the selection of quality measures.

Effective Date

Date of enactment.

Subtitle D—Physician Payments Sunshine Provision

Sec. 1451. Reports on Financial Relationships Between Manufacturers and Distributors of Covered Drugs, Devices, Biologics, or Medical Supplies Under Medicare, Medicaid, or CHIP and Physicians and Other Health Care Entities and Between Physicians and Other Health Care Entities

Current Law

Under section 1128B(b) of the Social Security Act, referred to as the federal anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration") in return for a referral or to induce generation of business reimbursable under a federal health care program. The statute prohibits both the offer or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of

any item or service that is reimbursable by a federal health care program. Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $25,000, imprisonment of up to five years, and exclusion from participation in federal health care programs for up to one year. However, a number of statutory and regulatory "safe harbors" to the anti-kickback statute protect various business arrangements from prosecution. Safe harbors include certain types of investment interests, personal services and management contracts, referral services, space rental or equipment rental arrangements, warranties, discounts, and employment arrangements.

In 2003, OIG issued "Compliance Program Guidance for Pharmaceutical Manufacturers" (68 Federal Register 23731), which stated that pharmaceutical companies and their employees and agents often engage in a number of arrangements that offer benefits to physicians or others in a position to make or influence prohibited referrals under the anti-kickback statute. Examples of remunerative arrangements between pharmaceutical manufacturers and parties in a position to influence referrals that were cited by OIG included entertainment, recreation, travel, meals, or other benefits in association with information or marketing presentations, as well as gifts, gratuities, and other business courtesies. OIG indicated these arrangements potentially implicate the anti-kickback statute if any one purpose of the arrangement is to generate business for the pharmaceutical company.

Under section 1877 of the Social Security Act, the federal prohibition on physician self-referrals, if a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS) for which payment may be made under Medicare or Medicaid, and the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral. "Financial relationship" is defined as either an ownership or investment interest or a compensation arrangement. An ownership or investment interest may be equity, debt, or other means; however, Section 1877(c) specifies that an ownership interest does not include certain investment securities which may be purchased on terms generally available to the public and meet additional requirements, or that are shares of certain regulated investment companies. A compensation arrangement means an arrangement involving remuneration between a physician or an immediate family member of such physician and an entity. Section 1877(f) requires an entity that provides covered services for which payment may be made under Medicare to report to the Secretary information on the entity's ownership, investment, and compensation arrangements, including the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians who have an ownership or investment interest in, or a compensation arrangement with the entity, or whose immediate relatives have such an ownership or investment interest or compensation relationship with the entity.

Multiple states and the District of Columbia have enacted legislation requiring pharmaceutical and other companies to disclose

gifts and payments made to physicians and other entities. These state laws generally require annual disclosures to the states of such gifts and payments. Certain categories of gifts and payments are exempted from reporting requirements under most of the state laws. For example, state laws may exempt product samples intended for free distribution to patients and gifts worth less than a certain amount. While companies may make a voluntary disclosure of these gifts and other payments, there are currently no similar federal reporting requirements.

Proposed Law

The bill would add a new Section 1128H of the Social Security Act to create certain reporting requirements applicable to manufacturers or distributors of a drug, device, biological, or medical supply for which payment may be made available under Medicare, Medicaid, or the State Children's Health Insurance Program, as well as hospitals or other entities that bill Medicare.

Under the section, beginning in 2011, a manufacturer or distributor that provides a payment or other transfer of value to a covered recipient (e.g., a physician, a pharmacist, a hospital, a medical school, or a group purchasing organization) or a recipient's designee would be required to annually submit specified information to the Secretary regarding the recipients, any payments or other transfers of value, and information about a provided drug sample. Payments or transfers of value include, among other things, gifts, food, or entertainment, travel or trips, honoraria, research funding or grants, education or conference funding and consulting fees, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a manufacturer (subject to exclusion), but do not include payments or transfers of five dollars or less, a loan of a covered device for a short-term trial period for evaluation purposes, items or services provided under a contractual warranty where the terms are specified in a purchase or lease agreement, items given to a patient who is not acting in a professional capacity, in-kind items for the provision of charity care, a dividend or other profit distribution from or ownership or investment interest in a publicly traded security and mutual fund, compensation paid by a manufacturer or distributor to an employee who works solely for a manufacturer or distributor, and any discount or cash rebate. The information submitted must include the aggregate amount of all payments or transfers of value from manufacturers to covered recipients, regardless of whether such payments or transfers were individually disclosed. If a manufacturer or distributor provides a payment to another entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor must disclose the payment or transfer under the name of the covered recipient.

Section 1128H would allow manufacturers and distributors to delay submission of their reports to the Secretary of payments and transfers of value made to covered recipients pursuant to certain services furnished as part of a product development agreement, or in connection with a clinical investigation of a new drug, device, biological, or medical supply. The information subject to delayed reporting would be considered confidential and would not be subject to disclosure under the Freedom of Information Actor other similar

federal, state, or local law until the date on which the information is reported.

Manufacturers and distributors that fail to submit the required information in a timely manner in accordance with regulations would be subject to a civil monetary penalty of at least $1,000 but not more than $10,000 for each payment or transfer of value not reported, up to a maximum of $150,000 for each annual submission of information. Any manufacturer or distributor that knowingly fails to submit information would be subject to a civil monetary penalty of at least $10,000 but not more than $100,000 for each payment or transfer of value, and may not exceed $1 million or, if greater, 0.1 percent of the total annual revenue of the manufacturer or distributor.

Each hospital or other health care entity, excluding a Medicare Advantage organization, that bills the Secretary under Medicare Part A or Part B would have to report on the ownership shares (other than shares generally available to the public or shares of certain regulated investment companies as described in Section 1877(c) of the Social Security Act) of each physician and the physician's immediate family members. Hospitals and other entities that fail to submit the required information in a timely manner in accordance with regulations would be subject to a civil monetary penalty of at least $1,000 but not more than $10,000 for each ownership or investment interest not reported. Any hospital or other entity that knowingly fails to submit information would be subject to a civil monetary penalty of at least $10,000, but not more than $100,000 for each ownership or investment interest not reported. All funds collected by the Secretary under section 1128H from the imposition of civil monetary penalties would be used to carry out the requirements of the section.

The bill would require the Secretary to establish procedures no later than September 30, 2011 and on June 30 each year after to ensure public availability of the submitted information through an Internet web site that is searchable, has a clear and understandable format, and that meets various other requirements. Manufacturer and distributors would be responsible for the accuracy of the information that is submitted to the Secretary and made available on the web site, and the Secretary would be required to establish procedures to ensure that a covered recipient has an opportunity to submit corrections to the manufacturer with regard to information made public with respect to the covered recipient. Under such procedures, the corrections must be transmitted to the Secretary. Information relating to drug samples and provider identification numbers would not be made available to the public by the Secretary, but may be made available outside of the Department of Health and Human Services for research or legitimate business purposes pursuant to data use agreements.

Under the bill, if a state attorney general has provided notice to the Secretary of the intent to proceed on a specific case and the Secretary has had an opportunity to bring an action and has declined to do so, the attorney general of a state would be permitted to bring an action against a manufacturer or distributor in the state for a violation of the section.

Section 1128H would require the Secretary to submit a report to Congress no later than April 1 of each year, beginning in 2011,

that includes information submitted in the preceding year by manufacturers and distributors and a description of any enforcement actions taken to carry out the section (including penalties imposed during the preceding year). The Secretary would also be required to submit to Congress a report on the results of the Disclosure of Physician Financial Relationships surveys required pursuant to section 5006 of the Deficit Reduction Act of 2005. This report would be submitted to Congress not later than 6 months after the date such surveys are collected and would be made publicly available on an Internet web site of the Department of Health and Human Services. In addition, no later than April 1 of each year, beginning in 2011, the Secretary would be required to submit to states a report that includes information submitted by manufacturers and distributors in the preceding year, as well as other information.

Additionally, beginning on January 1, 2011, Section 1128H would preempt any law or regulation of a state or its political subdivision that requires a manufacturer or distributor to disclose or report information regarding a payment or other transfer of value to a covered recipient, in accordance with the section. However, the section would not preempt state laws or regulations under which (A) the disclosure or reporting of information is not of the type required to be disclosed or reported under Section 1128H, (B) the information reported is required to be disclosed or reported to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes, or (C) the state requires the discovery or admissibility of the information in a criminal, civil, or administrative proceeding.

Subtitle E—Public Reporting on Health Care-Acquired Infections

Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on health care-associated infections

Current Law

Current law does not, in general, require the reporting of health care-associated infections (HAIs), although such reporting is required in a number of states. Several provisions in current federal law have established programs that are somewhat related.

First, Section 5001(c) of the Deficit Reduction Act (P.L. 109–171) requires the Secretary, by regulation, to identify certain preventable conditions that are not present on admission, and that therefore are acquired in the health care facility. Medicare Part A reimbursement is not provided for the care of these secondary conditions. This provision is implemented in CMS's annual Inpatient Prospective Payment System (IPPS) rule for hospitals. At this time, listed conditions include some that are unrelated to infection (such as incompatible blood transfusions, and trauma resulting from falls in the facility), as well as specific types of catheter-associated and surgical site infections. The rules explain that some other infections (such as infection with methicillin-resistant Staph. aureus, or MRSA) are not included because, among other things, it can be hard to determine, in an individual patient, whether an infection is associated with health care or was acquired previously.

Also, two voluntary CMS reporting programs established under current law may capture information related to HAIs. The Physician Quality Reporting Initiative (PQRI), established under Section

101(b) of the Tax Relief and Healthcare Act of 2006 (P.L. 109–432), provides incentive payments to physicians who report certain quality measures, which include instances of catheter-associated or surgical site infection. Information from this program is not publicly reported. The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program, originally established under Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173), requires participating hospitals to report quality data to CMS in order to receive a full annual payment update. Selected measures are publicly reported on the CMS Hospital Compare website. However, regarding infections, this program uses process measures (e.g., antibiotics were used properly in surgical patients) rather than outcome measures (e.g., a patient developed a surgical site infection).

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated into the American Recovery and Reinvestment Act of 2009 (P.L. 111–5), promotes the widespread adoption of health information technology (HIT). Among its provisions, the HITECH Act established a process for the development of interoperability standards that support the nationwide electronic exchange of health information among doctors, hospitals, patients, health plans, the federal government, and other health care stakeholders.

Proposed Law

This section would require the Secretary to provide, by regulation, that in order to participate in Medicare and Medicaid, hospitals and ambulatory surgical centers would have to report certain health care-associated infections (HAIs) that develop in the facility. The Secretary would specify the types of information that must be reported, and develop reporting protocols through the Centers for Disease Control and Prevention (CDC), assuring that such protocols are coordinated with systems established under the HITECH Act. The Secretary would be required: to establish procedures regarding the validity of reported data to assure appropriate comparisons between facilities; to promulgate, through the Director of CDC, regulations to carry out this section, within one year of enactment; and to post information from the system on the HHS website in a manner that permits comparisons by facility and by patient demographic characteristics.

This section would also require the Secretary annually to report to Congress on specified aspects of the program, and would provide that this section should not be construed as preempting or otherwise affecting State laws relating to the disclosure of information on HAIs or patient safety procedures for a hospital or ambulatory surgical center. It would also define an HAI and its relationship to the receipt of care, and would clarify that for the purposes of this section, hospitals include critical access hospitals.

For hospitals and ambulatory surgical centers, reporting requirements would take effect when specified by the Secretary, but not later than 2 years after enactment. Within 18 months of enactment, the Comptroller General would be required to report to Congress regarding the reporting program, and the Secretary would be required to report to Congress regarding the appropriateness of ex-

panding reporting requirements to include additional information, such as health care worker immunization rates.

Reason for change

Health care-associated infections (HAIs) are a result of treatment in a healthcare service setting such as a hospital or an ambulatory surgery center, but secondary to the patient's original condition. Studies have shown that such infections have been increasing over the past few years due to factors such as increasing drug resistance of bacteria and improper infection control measures. Collection of data is critical as a public health measure so as to identify and respond to emerging threats. Over 20 States now have mandatory reporting for health facilities on health care-associated infections. This policy would require hospital, critical access hospitals and ambulatory surgery centers that participate in Medicare and Medicaid to report HAIs to the CDC to improve public health. The Secretary would determine what infections information would be collected and how it is collected.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

Sec. 1501. Distribution of Unused Residency Positions

Current Law

With certain exceptions, the Balanced Budget Act of 1997 (BBA, P.L. 105–33) limited the number of allopathic and osteopathic residents for which Medicare would reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108–173, MMA) authorized the redistribution of up to 75% of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs. Any adjustments made to teaching hospitals' resident limits were permanent. Rural teaching hospitals with less than 250 beds were exempt from the redistribution of any of their unfilled positions. Under the redistribution program, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for direct graduate medical education (DGME) and indirect medical education (IME) payments. Hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within 3 cost reporting periods beginning July 1, 2005. MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.

Proposed Law

The Secretary would reduce the otherwise applicable resident limit for a hospital that has residency positions that were unused. Unused positions would be established when a hospital's reference residence level is less than its otherwise applicable resident limit.

The reduction would be effective for portions of cost reporting periods occurring on or after July 1, 2011. Hospitals that are members of the same affiliated group would be subject to redistribution. The Secretary would adjust the determination of available slots for affiliated hospitals depending upon the extent that these hospitals could demonstrate that they are filling any additional residents slots allocated to other hospitals through an affiliation agreement. Ninety percent of unused slots would be redistributed to qualifying hospitals. The increase in resident training positions would be distributed to qualifying hospitals not later than July 1, 2011.

A hospital's reference residence level would be established as the highest resident level of any of the 3 most recent cost reporting periods (ending before the date of enactment). Hospital cost reports that had been settled or those that had been submitted, subject to audit, would be used to establish the residence level. Also, upon timely request, a hospital's reference resident level could be increased to reflect an expansion or planned expansion of an existing residency training program that is not reflected on the most recent settled or submitted cost report. The increase would occur after audit and would include the previous redistribution of unused resident positions that occurred under MMA. The Secretary would be authorized to determine an alternative resident reference level for hospitals that submit a timely request for an increase in their reference resident level due to a planned expansion before the start of the 2009–2010 academic year. A hospital's resident reference level would reflect any increases in slots granted under the prior redistribution of resident slots under the MMA.

The Secretary would be required to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number for portions of cost reporting periods that occur on or after July 1, 2011. The aggregate number of increases in resident limits may not exceed the estimated aggregate reduction in resident limits. In no case would more than 20 FTE additional residents be made available to a qualifying hospital.

A hospital that qualifies for an increase in its otherwise applicable resident limit would be required to ensure that its base level of primary care residents is increased by the number of additional primary care residents provided to the hospital under this section. The hospital would have to assign all additional resident positions to primary care residents. The hospital's residency programs would have to be fully accredited or, if not yet in operation as of the base year, the hospital would have to be actively applying for such accreditation for the program. A hospital's base level of primary care residents is the level of such residents in a base period determined without regard to whether such positions were in excess of the otherwise applicable resident limits. Hospitals receiving positions would be required to maintain records and periodically report on the number of primary care residents in its training programs. As a condition of continuing payment for a cost reporting period, the hospitals would be required to maintain the base level of positions at not less than the sum of the level of primary care resident positions before receiving additional positions plus the number of additional positions.

When determining which qualifying hospitals would receive an increase in their otherwise applicable resident limit, the Secretary would take into account the demonstrated likelihood that a hospital would fill the positions within the first 3 cost reporting periods beginning on or after July 1, 2011. Also, the Secretary would distribute the resident slots based on the following criteria: (1) the hospital had a reduction in the resident training positions under this section; (2) the hospital has a 3-year primary care residency training program, such as family practice and general internal medicine; (3) the hospital has formal arrangements, as determined by the Secretary, that place greater emphasis upon training in federally qualified health centers, rural health clinics, and other nonprovider settings and to hospitals that receive additional disproportionate share hospital payments and emphasize training in an outpatient department; (4) the hospital has resident training positions in excess of its otherwise applicable resident level as of July 1, 2009; (5) the hospital has formal arrangements that place greater emphasis on training in a health professional shortage area or health professions needs area; or (6) the hospital is in a State with a low resident-to-population ratio (including a greater preference for those States with lower resident-to-population ratios).

The per resident amounts (PRAs) for the resident positions distributed under this provision would equal the hospitals' PRAs for primary and nonprimary care positions for the purposes of calculating direct graduate medical payments. The indirect medical education adjustment for the resident positions distributed under this provision would be computed in the same fashion as the hospital's existing resident positions.

Reasons for change

The healthcare system is increasingly uncoordinated and complex, but a solid primary care workforce can help to support a well coordinated and integrated delivery model. Despite clear advantages of a strong primary care workforce, the number of primary care slots and medical students choosing primary care as a specialty has decreased over the past decade. This is the case even though the total amount of the physician workforce has remained stable Studies have recently shown that while 35 percent of the current physician workforce is in primary care, 21 to 24 percent of graduating medical students choose primary care medicine as a career specialty. According to the Council of Graduate Medical Education (COGME), since the Graduate Medical Education (GME) cap was put in place in 1996, primary care internal medicine positions in the annual student match have fallen 57 percent, primary care pediatric positions have fallen by 34 percent, and family medicine positions have fallen by 18 percent. Over the past ten years, nearly all graduate medical expansion in teaching hospitals has been in subspecialty medicine. Family practice residency programs, and three year training programs that emphasize a generalist training have decreased or have shut down as well.

In their May 2009 report, COGME stated that graduate medical education should be realigned to meet society's evolving healthcare needs. COGME recommended an emphasis on training more primary care physicians, training residents capable of practicing in innovative delivery care models such as patient-centered medical

homes and accountable care organizations, and increasing the accountability of graduate medical education's role in public health. Similarly, in its June 2009 report, MedPAC's recognized that residents will best learn the skills needed to provide high-quality, efficient care when medical education occurs in settings where such care is actually performed and will explore policies in their future work that might link medical education incentives with delivery system reforms. This policy is intended to increase training of primary care physicians in a broader array of settings in order to meet the future healthcare needs of the American public.

The Committee notes that some policymakers point to earlier COGME reports to argue for the need for more residency slots; however, COGME now recognizes that earlier calls for increased residency slots focused on the growth in medical schools, and failed to take into account the fact that GME positions already exceed allopathic medical school slots by 30 percent. For instance, in 2007–2008, the U.S. graduated about 17,500 allopathic students, but had more than 25,000 first year residency positions. COGME points out that first year residency positions grew 8 percent from 2002 and 2007 and that this expansion will accommodate increases in medical school production. The shortcoming is not in the number of medical residents being trained, but that nearly all of this expansion is in subspecialty training, resulting in a drop in primary care physicians.

The legislation increases primary care physicians by directing the Secretary to redistribute residency positions that have been unfilled for the prior 3 cost reports and direct those slots for training of primary care physicians. Special preference will be given to programs that saw a reduction in their slots under this section, have formal arrangements to train residents in ambulatory settings or shortage areas, operate three year primary care residency programs, currently operate residency programs over their cap, or are located in states with low resident to population ratios. Primary physicians are trained via three year general medicine, pediatrics or family practice residency programs. Within this universe of residency programs are a select number of programs that place emphasis on a generalist curriculum (such as family practice programs) and referred to as "three-year primary care residency training programs, as compared to the "categorical" or basic programs where a resident will then go on to specialize. This provision directs the Secretary to give preference to these "three year primary care" programs in general internal medicine or family practice. The increase in resident training positions would be distributed to qualifying hospitals not later than July 1, 2011.

Effective date

Cost reporting periods beginning on or after July 1, 2011.

Section 1502. Increasing Training in Non-Provider Settings

Current Law

Medicare reimburses the direct costs of graduate medical education (DGME) for approved residency training programs without regard for the setting where the residents' activities relating to patient care are performed as long as the hospital incurs all, or sub-

stantially all, of the costs for the training program in that setting. Through regulation, CMS has defined all, or substantially all costs, as 90% of resident stipends and fringe benefits and costs associated with a supervising physician. However, as presently administered, a hospital cannot include the time spent by residents working at a non-hospital site if it incurs all, or substantially all, of the costs for only a portion of the residents in that program at the non-hospital site.

Section 1886(k) provides for payment to qualified nonhospital providers, such as FQHCs and rural health clinics, for their direct costs of medical educations if those costs are incurred in the operation of an approved medical residency training program.

Proposed Law

Effective for cost reporting periods beginning on or after July 1, 2009, all time spent by a resident would count towards the determination of a FTE resident with respect to Medicare's direct graduate education payment, without regard to the setting where the activities are performed, if the hospital incurs the costs of the stipends and the fringe benefits of the resident during the time the resident spends in that setting. Any hospital claiming payment for the time spent in a non-provider setting would be required to maintain and make available necessary records regarding the amount of time and this amount in comparison to the amounts of time in a specified base year.

Effective for discharges on or after July 1, 2009, all the time spent by a resident in patient care activities in a non-provider setting would be counted towards the determination of a FTE resident with respect to Medicare's indirect medical education payment if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time spent in that setting.

The Office of the Inspector General (OIG) would be required to analyze the resident data to assess the extent to which there is an increase in time spent by medical residents training in non-provider settings. No later than 4 years after the date of enactment the OIG would submit a report to Congress its analysis and assessment.

The Secretary would conduct a demonstration project where an approved teaching health center would be eligible for direct medical education payments for its own direct cost of graduate medical education activities for primary care residents as well as for the direct costs of such graduate medical education activities of its contracting hospital for such residents. Under the project, an approved teaching health center would contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program. The center would be responsible for payment of the hospital's costs of the salary and fringe benefits for residents. The hospital's full-time equivalent resident amount would not affect the contracting hospital's resident limit. The contracting hospital would not reduce the number of residents in its primary care residency training program. An approved teaching health center would be a non-provider setting, such as a Federally qualified health center or rural health center that develops and operates an accredited primary care residency program for which

funding would be available if it were operated by a hospital in connection with a hospital.

Reason for change

MedPAC and COGME have recommended that physicians be trained at alternative care settings such as ambulatory settings. COGME called for a "broadening of the definition of the training venue" and emphasized preparing a physician workforce for outpatient care, where most of the health care takes place, and to consider placing physicians at rural and community health centers and physician offices. Residents should also be exposed to patient care coordination in a variety of health care settings. Teaching hospitals face considerable financial incentives and regulatory barriers that discourage them from rotating residents to nonhospital settings.

The intent of this legislation is to decrease the regulatory barriers so that residents can increase their training in non-provider settings (i.e., outside the acute care hospital). This policy modifies the rules that govern when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in non-provider settings so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs any costs such as fringe and benefits. A study by the Office of the Inspector General shall assess the impact of this policy on increasing physician training in non-provider settings. The changes are effective for discharges on or after July 1, 2009 and the OIG study is scheduled to report to Congress 4 years after the date of enactment.

A demonstration project is established to allow community health centers to host an approved primary care residency program and receive DGME for itself and for the hospital that it will contract with to provide the inpatient training. This demonstration project will inform the Secretary and Congress on the feasibility of health centers hosting a residency program and inform possible alternative payment methodologies for nonhospital teaching sites. While the Committee recognizes the importance of training in non-provider settings, including Federally Qualified Health Centers, the Committee does not think it is appropriate for teaching health centers to receive a hospital's IME payments since the payment methodology is based on Medicare patient activities that occur in the inpatient setting. The Committee also questions whether indirect medical education costs are incurred by an FQHC and notes that the average Medicare share for FQHCs is less than 10 percent. While the Committee supports the need for more training in the non-provider setting, this must be balanced against the competing priority of ensuring that Medicare dollars are spent on Medicare patients.

Effective date

Cost reporting periods beginning on or after July 1, 2009.

Sec. 1503. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

Current Law

Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS. Certain non-patient care activities that are part of an approved training program are not allowable for DGME or IME payment purposes. With respect to training that occurs in hospital settings, Medicare does not include the time that residents spend in non-patient care activities, including didactic activities, when calculating IME payments. With respect to training that occurs in nonhospital settings, Medicare would not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.

Proposed Law

When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-direct patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. The term "nonprovider setting that is primarily engaged in furnishing patient care" would be a nonprovider setting in which the primary activity is the care and treatment of patients as defined by the Secretary. Reimbursable nonpatient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration.

When calculating IME payments, Medicare would adopt the same rules about counting residents' leave time. Medicare would also include all the time spent by residents in approved training programs on certain nonpatient care activities (including didactic conferences and seminars, but not in certain research activities that are not associated with the treatment or diagnosis of an particular patient) if the hospital is an IPPS hospital, a hospital paid under the IPPS for Puerto Rico, is a hospital paid under a state specific hospital reimbursement system, or is a provider-based hospital outpatient department.

Except as otherwise provided, these provisions would be effective for cost reporting periods beginning on or after January 1, 1983. The provisions affecting DGME would apply to cost reporting periods on or after July 1, 2008. The provisions affecting IME would apply to cost 317 reporting periods on or after October 1, 2001. This section would not affect the interpretation of the law in effect prior to that date. The provisions would not be implemented in a manner that would require reopening of any settled hospital cost reports where there is not a jurisdictionally proper appeal pending on IME and DGME payments as of the date of enactment.

Reason for change

Physicians in training need to learn critical evidenced based medicine and participate in scholarly activities related to the management of their patients. They devote time during their residency training to participate in didactic and scholarly activities that broadens their clinical knowledge base. The policy is to modify the rules to allow for inclusion of didactic and scholarly activities and other activities such as research related to the care of their patients. The provisions affecting IME would apply to cost reporting periods on or after October 1, 2001 and the provisions affecting DGME would apply to cost reporting periods on or after July 1, 2008.

Effective date

Subsection (a)(1)(B) pertaining to direct graduate medical education is effective for cost reporting periods beginning on or after July 1, 2008. Subsection (b), pertaining to indirect medical education is effective for cost reporting periods beginning on or after October 1, 2001. All other provisions are effective for cost reporting periods beginning on or after January 1, 1983.

Sec. 1504. Preservation of Resident Cap Positions from Closed and Acquired Hospitals

Current law

With certain exceptions, the Balanced Budget Act (BBA) of 1997 limited the number of allopathic and osteopathic residents for which Medicare would reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. If a teaching hospital closes (defined as withdrawing participation in the Medicare program), CMS permits a temporary cap increase to other teaching hospitals to accommodate residents suddenly displaced from the closed hospital. Upon completion of their training, the residency slots cease to exist.

A hospital with a newly established residency program may receive an adjustment to its FTE cap (which otherwise would be zero) if it establishes one or more new medical residency training programs, but only for new programs established within 3 academic years after residents begin training in the first new program. CMS recently put forth a final rule on July 31, 2009 that clarifies that a "newly established" residency program for Medicare GME purposes is not a program that existed previously at another hospital. In determining that a program is truly new, CMS will use certain "supporting factors," such as whether the program director, teaching staff, and residents are different. CMS will also consider whether the program relocated from a hospital that closed, and whether that program is part of any existing hospital's FTE cap determination. If the program did relocate from a closed hospital and that program is not part of any existing hospital's FTE cap determination, then even if there are significant similarities between the program in terms of the program director, teaching staff, or residents, CMS could consider the program that was transferred from the closed hospital to be new for Medicare direct GME and IME, since there would be no danger that an FTE cap adjustment to reflect a new program would result in duplicative FTE caps. CMS

also has established certain regulations governing Medicare's provider enrollment requirements that determine under what circumstances providers can bill the Medicare program including those involved in change of ownership (CHOW) transactions. Very generally, in order to acquire a teaching hospital's resident cap under a CHOW transaction, the acquiring entity must retain the original provider agreement of the provider it is acquiring. However, the acquiring entity would also assume all liabilities associated with that provider agreement.

Starting August 29, 2005 (the day after Hurricane Katrina), hospitals were permitted to form emergency affiliation agreements if located in federally declared disaster areas starting the first day of a Section 1135 emergency period. Under 42 Code of Federal Regulations (CFR) 413.79, a home hospital located in such an area that experiences at least a 20% decline in inpatient occupancy can temporarily transfer its resident cap to a host hospital.

Proposed Law

The Secretary would promulgate regulations to establish a process where the FTE residency cap slots in a hospital with an approved medical residency program that closes on or after a date that is 2 years before the date of enactment could be used to increase the otherwise applicable residency limit for other hospitals in the State. The increase in residency programs would be distributed to one or more hospitals in the State in a manner specified by the Secretary. This process would be consistent with any recommendations submitted by the senior health official designated by the chief executive officer of the state in question provided that the recommendations are not submitted later than 180 days after the date of a hospital closure. In cases where a hospital closed before date of enactment, the time limit would be 180 days from the date of enactment. The aggregate number of increased residency limits in the state would equal the number of FTE resident cap slots from the hospital(s) that closed. These provisions would not affect any temporary adjustment to a hospital's FTE resident cap established under 42 CFR 413.79 as in effect on the date of enactment.

Reason for change

When hospitals close, the residency slots previously associated with those hospitals are no longer eligible for further Medicare reimbursement once the existing residents complete their training. This occurs regardless of any continued need for those residency slots to meet current or future workforce needs in the community or state. This provision allows for continued funding of those slots at other hospitals within the state, taking into consideration recommendations from the senior health official in the state when determining which hospitals shall receive upward adjustments or new residency caps.

Sec. 1505. Improving Accountability for Approved Medical Residency Training

Current law

Medicare will reimburse teaching hospitals for the direct and indirect costs associated with an approved teaching program accred-

ited by an independent entity, such as the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Medicare has never linked its payments to promoting or fostering any goals in medical education.

Proposed law

Certain goals of medical residency training programs would be established. Specifically, resident training would be designed so that physicians would be able to: (1) work effectively in various non-provider settings; (2) coordinate patient care within and across settings; (3) understand the relevant cost and value of various diagnostic and treatment options; (4) work effectively in inter-professional and multi-disciplinary teams in provider and non-provider settings; (5) identify systematic errors in health care delivery and implement solutions for such errors; and (6) be meaningful electronic health record users.

GAO would be required to evaluate the extent to which medical residency training programs are meeting the above workforce goals in a range of residency programs, including primary care and specialties; and have the appropriate faculty expertise to teach the topics required to achieve such goals. The study would be submitted to Congress no later than 18 months after the date of the enactment. The study would include recommendations with respect to the development of curriculum requirements and an assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association.

Reason for change

MedPAC recommends that the residency training experience should encourage physicians to increase care coordination and assume greater accountability for quality of care. Graduate medical education should train a future physician workforce exposed to innovative delivery models that would support more integration. A MedPAC sponsored study conducted by RAND pointed out that the curricula of residency training programs fall short of recommendations by the Institute of Medicine and other experts on items such as formal training or experience in multidisciplinary teamwork, cost-awareness in clinical decision-making, comprehensive health information technology, and patient care in nonhospital settings. Residents should be trained in innovation delivery systems that will support coordinated care and enhance an integrated approach. The Accreditation Council for Graduate Medical Education has also included similar goals for residency programs to improve the training of residents. The COGME report calls for "making accountability for the public's health the driving force for graduate medical education." The report further states that the $10 billion spent annually on GME should have parameters on how our physician workforce should be trained and the type of training residents should receive.

This policy is intended to highlight broad goals for residency programs to improve their accountability. Such goals include: (1) work effectively in various non-provider settings; (2) coordinate patient care within and across settings; (3) understand the relevant cost and value of various diagnostic and treatment options; (4) work effectively in inter-professional and multidisciplinary teams in pro-

vider and non-provider settings; (5) identify systematic errors in health care delivery and implement solutions for such errors; and (6) be meaningful electronic health record users.

The Comptroller General shall conduct a study to evaluate the extent to which residency training programs will meet the goals described in this provision and will report to Congress not later than 18 months after the enactment of this legislation.

TITLE VI—PROGRAM INTEGRITY

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

Sec. 1601. Increased Funding and Flexibility to Fight Fraud and Abuse

Current Law

The Health Care Fraud and Abuse Control (HCFAC) account funds activities to fight health care fraud. The HCFAC program along with the Medicare Integrity Program (MIP) were both established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191) which sought to increase and stabilize federal funding for health care anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud. MIP funding supports the program integrity activities undertaken by CMS contractors.

For HCFAC, HIPAA appropriated funds to the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI) for antifraud activities undertaken for fiscal years 1997 through 2003. Funds are appropriated to the Account from the Medicare Part A Trust Fund in amounts as the Secretary and the Attorney General certify are necessary to support audits, investigations, evaluations, and prosecutions related to health care fraud. For HHS and DOJ, the legislation authorized an amount, beginning at $104 million for FY1997, equal to the limit for the preceding year increased by 15%. Within this amount, the legislation authorized minimum and maximum appropriations for the HHS OIG. The maximum OIG appropriation increased from $70 million in FY1997 to $160 million in FY2003. For each fiscal year after 2003, the amount was capped at the 2003 level. In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109–432) which extended the mandatory annual appropriation for HCFAC to 2010. For fiscal years 2007 through 2010, the mandatory annual appropriation is the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers (CPI–U). For years after FY2010, the annual appropriation remains at the FY2010 level.

The MIP program authorizes the Secretary of HHS to enter into contracts with private organizations to conduct program integrity activities such as provider audits and medical review of claims. The largest share of the HIPAA appropriation was dedicated to the MIP program. Funding for MIP increased from $440 million in FY1997 to $720 million in FY2003. For fiscal years 2004 and 2005, the annual MIP appropriation remained at the FY2003 level. In 2005, Congress passed the Deficit Reduction Act (DRA, P.L. 109–171) which raised funding for the MIP program by $112 million for

FY2006 to implement program integrity and oversight activities for the Medicare prescription drug benefit. This increased the annual MIP appropriation from $720 million to $832 million for FY2006 only. Congress did not increase funding for MIP in TRHCA. Therefore the mandatory annual appropriation for MIP remains at $720 million.

Proposed Law

The provision would increase funding for HCFAC by $100 million annually beginning with FY2011. Funding would be appropriated to HHS, the DOJ, and MIP in the same manner as is currently appropriated in statute. Funding allocated to MIP would be authorized for HCFAC activities as well as MIP activities and would not have to be distributed solely to private organizations to conduct program integrity activities. Funding for both HCFAC and MIP would be available without further appropriation until expended.

Reason for Change

According to the Congressional Budget Office, for every $1.00 that the government spends in increased funding for HCFAC, there is a $1.75 return on that investment. This increased funding will allow for the implementation of the measures in this bill aimed at fighting waste, fraud, and abuse; and will result in an overall increase in program integrity.

Effective Date

January 1, 2010.

Subtitle B—Enhanced Penalties for Fraud and Abuse

Sec. 1611. Enhanced Penalties for False Statements on Provider or Supplier Enrollment Applications

Current Law

Medicare statute provides the Secretary with general authority to prescribe regulations for the efficient administration of the Medicare program. Under this authority, the Center for Medicare and Medicaid Services (CMS) has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program and receive billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. Medicare enrollment activities, such as processing and reviewing applications, are handled by private contractors. CMS may deny a provider or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: noncompliance with enrollment requirements, exclusion from participation in Federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application.

Medicaid statute delegates the administration of the Medicaid program to the states. There is considerable variation in how states administer their provider enrollment processes. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Written agreements require that providers and suppliers maintain specific records, disclose cer-

tain ownership information, and grant access to federal and state auditors to books and records.

Section 1128A(a) of the Social Security Act (SSA) authorizes the imposition of Civil Monetary Penalties (CMPs) and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs. Under section 1128A(a)(1)(D) of the Act, a person who knowingly presents or causes to be presented a claim to federal or state agencies that the Secretary determines is for an item or service furnished during a period when the person was excluded from participation in the federal health care program under which the claim was made is subject to a civil monetary penalty of up to $10,000 for each item or service furnished, and an assessment of up to three times the amount claimed for each item or service.

Proposed Law

This provision would subject providers and suppliers applying to enroll or renewing enrollment in federal health care programs to CMPs for providing false information on an enrollment application. Medicaid managed care plans, MA plans, and PDP plans would also be subject to CMPs for providing false information on applications to participate in federal health care programs.

Specifically, the provision would provide that a person who knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact on an application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a federal health care program would be subject to a CMP of $50,000 for each violation. In addition to providers and suppliers, the provision would also apply to Medicaid managed care organizations, Medicare Advantage (MA) organizations and MA plans, Prescription Drug Plan (PDP) sponsors and plans, and providers and suppliers that participate in these Medicare or Medicaid plans. In addition, such a person may be subject to an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation.

The provision would also eliminate the requirement for a determination by the Secretary when a person knowingly presents or causes to be presented a claim for an item or service furnished during a period when the person was excluded under federal law from the federal health care program under which the claim was made.

Reason for Change

The new provisions will increase the quality of data supplied on an application, agreement, bid, or contract when providers or suppliers enroll in a federal health care program.

Effective Date

These amendments would apply to acts committed on or after January 1, 2010.

Sec. 1612. Enhanced Penalties for Submission of False Statements Material to a False Claim

Current Law

Section 1128A (a) of the SSA authorizes the imposition of CMPs (CMPs) and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including the imposition of penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.

Proposed Law

The bill would create a new section 1128A (a) (9) of the SSA, providing that persons who knowingly make, use, or cause to be made or used any false statement or record material to a false or fraudulent claim submitted for payment to a federal health care program would be subject to a civil monetary penalty of $50,000 for each violation.

Reason for Change

The new provisions will increase the quality of data supplied on claims submitted for payment and will deter false or fraudulent claims.

Effective Date

These amendments would apply to violations committed on or after January 1, 2010.

Sec. 1613. Enhanced Penalties for Delaying Investigations

Current Law

Section 1128A (a) of the SSA authorizes the imposition of CMPs and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including the imposition of penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.

The Secretary is required to provide for the annual auditing of the financial records of at least ⅓ of MA plans. Each contract with a MA plan is required to provide that the Secretary have the right to inspect or evaluate the quality, appropriateness and timeliness of services performed under the contract. Contracts must also provide the Secretary with right to audit any plan's books and records related to the plan's ability to bear risk or to the services performed, including determinations of amounts payable under the contract.

Proposed Law

The bill would create a new provision, section 1128A (a) (10), providing that persons who fail to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Office of the Inspector General (OIG), for the purpose of audits, investigations, evaluations, or other statutory functions of the OIG, be subject to CMPs of $15,000 for each day of failure. The provision would also modify the contractual requirements for MA plans to allow the Secretary to conduct timely audits and inspections of MA plans.

Reason for Change

According to an October 2007 report by the Government Accountability Office (GAO), the Centers for Medicare and Medicaid Services (CMS) did not fulfill its statutory mandate to audit the financial records of ⅓ of MA plans for the years 2001–2006. Of the audits that were conducted, GAO found that CMS was limited in its ability to pursue financial recoveries based on the audits that were performed, because CMS did not use its statutory authority to include in contracts with MA plans an explanation of its audit authority and description of the steps to be taken to pursue deficiencies identified by these audits. This section requires that future contracts with MA plans contain this language, and imposes stronger daily penalties for the obstruction of audits, in order to facilitate more timely and efficient performance of this statutory duty by CMS in addition to audits, investigations or

Effective Date

These amendments would apply to violations committed on or after January 1, 2010.

Sec. 1614. Enhanced Hospice Program Safeguards

Current Law

Medicare statute mandates the establishment of minimum health and safety standards that must be met by providers participating in the Medicare and Medicaid programs (i.e. hospitals, hospices, nursing homes, and home health agencies). In order to receive payment, providers and suppliers must meet these health and safety standards, often referred to as Conditions of Participation (CoPs). Generally, state agencies, under contract with CMS, survey providers to determine compliance with CoPs. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body. If a provider has been found to be non-compliant with its CoPs, CMS has the authority to impose certain sanctions, including revoking the provider's participation agreement. States also have the authority to impose sanctions on Medicare and Medicaid participating facilities found to be noncompliant with CoPs.

Proposed Law

This provision would add a new section, Section 1819A, to the SSA that would require the Secretary to develop and implement intermediate sanctions to apply to hospices that, based on a determination by the Secretary, demonstrate a substandard quality of

care and fail to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals provided care and services by the agency or organization involved. The sanctions may include CMPs of up to $10,000 for each day of non-compliance or in the case of a per instance penalty not more than $25,000, a denial of all or part of future Medicare or Medicaid payments to which the hospice is entitled (which would terminate upon the Secretary's finding that the hospice program no longer demonstrated substandard quality and met other requirements as determined by the Secretary), requiring the appointment of managers to oversee the operation of the hospice program, correction plans, and staff training The sanctions could be imposed in addition to those imposed under State or Federal law and would not be construed as limiting other available remedies. The Secretary would have until January 1, 2012 to develop and implement the sanctions.

By July 1, 2011, the Secretary would be required to create the specific procedures and conditions under which the relevant sanctions would apply, including the amount of any fines and severity of the sanctions. The conditions would be required to minimize the time between the identification of deficiencies and imposition of sanctions, and would provide for more severe fines for repeated deficiencies. The due process protections provided in the CMP law (SSA, Section 1128A), such as written notice and the right to a hearing, would apply in the same manner to the imposition of a CMP for hospices.

This provision would also require the Secretary to take immediate action to correct any identified deficiencies that immediately jeopardize the health and safety of patients being cared for in a I hospice. The action would consist of either appointing managers to oversee the operations of the hospice or terminating the hospice's participation in federal health care programs. The Secretary would be authorized to impose additional remedies if necessary. If the Secretary determines that identified deficiencies do not immediately jeopardize the patients' health and safety, the Secretary, in lieu of terminating the providers' participation in the program, may impose other intermediate sanctions. If after a period of intermediate sanctions, the deficiencies have not been corrected, the Secretary would be required to terminate the providers' participation in federal health programs. The Secretary would also be authorized to impose CMPs on hospice providers for any former days of non-compliance with federal health and safety standards.

These provisions would also apply to hospice programs participating in Medicaid and CHIP.

Reason for Change

The new provisions will enable CMS to take intermediate action in the case of poorly performing hospices, when previously the only option was exclusion. The section also instructs and authorizes the Secretary to take immediate action if deficiencies immediately jeopardize the health and safety of beneficiaries.

Effective Date

Date of enactment.

Sec. 1615. Enhanced Penalties for Individuals Excluded from Program Participation

Current Law

Section 1128A (a) of the SSA authorizes the imposition of CMPs and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including the imposition of penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.

Proposed Law

The bill would create a new provision, section 1128A(a)(11) of the SSA, providing that a person who orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or any other item or service, during a period when the person has been excluded from participation in a federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program, be subject to a civil monetary penalty of $50,000 for each order or prescription. This amendment would apply to violations committed on or after January 1, 2010.

Reason for Change

The new provision will create a disincentive for excluded persons to violate that exclusion by continuing to prescribe services payable by a federal health program.

Effective Date

These amendments apply to violations committed on or after January 1, 2010.

Sec. 1616. Enhanced Penalties for Provision of False Information by Medicare Advantage and Part D Plans

Current Law

MA plans enter into contracts with the Secretary to participate in the Medicare program. The Secretary has the authority to impose sanctions and CMPs on MA plans that violate the terms of the contract. Among the violations are failing to provide medically necessary care; imposing excess beneficiary premiums; expelling or refusing to re-enroll beneficiaries; discouraging or denying enrollment among eligible individuals expected to require future medical services; misrepresenting or falsifying information; failing to comply with balance billing requirements; interfering with a provider's advice to beneficiaries; and contracting with providers excluded from the Medicare program. For violations related to discouraging or denying enrollment or misrepresenting information provided to the Secretary, the Secretary can impose a maximum penalty of $100,000. For all other violations, the maximum penalty is $25,000.

The Secretary has the authority to impose additional penalties for imposing excess beneficiary premiums and engaging in activities that discourage enrollment.

Proposed Law

This provision would enhance penalties for MA and Part D plans that misrepresent or falsify information to include an assessment of up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information. The provision would apply to violations committed on or after January 1, 2010.

Reason for Change

The new provision will improve the accuracy of information submitted by MA and Part D plans.

Effective Date

These amendments apply to violations committed on or after January 1, 2010.

Sec. 1617. Enhanced Penalties for Medicare Advantage and Part D Marketing Violations

Current Law

MA plans enter into contracts with the Secretary to participate in the Medicare program. The Secretary has the authority to impose sanctions and CMPs on MA plans that violate the terms of the contract. Among the violations are failing to provide medically necessary care; imposing excess beneficiary premiums; expelling or refusing to re-enroll beneficiaries; discouraging or denying enrollment among eligible individuals expected to require future medical services; misrepresenting or falsifying information; failing to comply with balance billing requirements; interfering with a provider's advice to beneficiaries; and contracting with providers excluded from the Medicare program. For violations related to discouraging or denying enrollment or misrepresenting information provided to the Secretary, the Secretary can impose a maximum penalty of $100,000. For all other violations, the maximum penalty is $25,000. The Secretary has the authority to impose additional penalties for imposing excess beneficiary premiums and engaging in activities that discourage enrollment.

Proposed Law

This provision would increase the number of violations that could be subject to the imposition of sanctions and CMPs by the Secretary. Beginning January 1, 2010, plans that: (1) enroll individuals in a MA or Part D plan without their consent (except Part D dual eligibles), (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements, including CMS guidance, or (4) employ or contract with an individual or entity that commits a violation would be subject to sanctions imposed by the Secretary. Sanctions would apply to any employee or agent of a MA or Part D plan, or any provider or supplier who contracts with a MA or Part D plan.

Reason for Change

The new provision will reduce the "churning" of beneficiaries by agents or brokers and clarifies that plans may be sanctioned for actions undertaken by their employees, agents, brokers. Providers, or suppliers.

Effective Date

These amendments apply to violations committed on or after January 1, 2010.

Sec. 1618. Enhanced Penalties for Obstruction of Program Audits

Current Law

The OIG has permissive authority (i.e. discretion) to exclude an entity or individual from a federal health program for a conviction related to the obstruction of a health care fraud investigation.

Proposed Law

This provision would expand the OIG's permissive exclusion authority to include a conviction related to the obstruction of an audit related to health care fraud as well as an investigation or audit related to the use of funds received from any health care program. The provision would apply to violations committed on or after January 1, 2010.

Reason for Change

The new provision will create a strong disincentive for the obstruction of program audits.

Effective Date

These amendments apply to violations committed on or after January 1, 2010.

Sec. 1619. Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs

Current Law

Section 1128 of the Social Security Act provides that the Secretary (and through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Exclusion is mandatory for those convicted of certain criminal offenses, and generally the exclusion cannot be for a period of less than five years. OIG also has permissive authority exclude an individual or entity from a federal health program, which includes the discretion to determine whether and for how long to impose an exclusion. A permissive exclusion may be imposed under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

Under 42 C.F.R. § 1001.1901, unless and until an excluded individual or entity is reinstated into a federal health care program, no payment will be made by a program for any item or service furnished by the individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.

Proposed Law

The bill would amend section 1128(c) to clarify the effect of an exclusion of an individual or entity on payment made under a federal health care program. The section would provide that payment cannot be made from any federal health care program with respect to an item or service furnished (1) by an excluded individual or entity, or (2) at the medical direction, or on the prescription of an authorized individual (e.g., a physician) when the person submitting a claim for the item or service knew or had reason to know of an individual's exclusion. Despite this prohibition, the bill would permit payment to be made for emergency items or services (not including items or services furnished in an emergency room of a hospital) that are furnished by these individuals and entities. For purposes of this section, as well as sections 1128A and 1128B (dealing with civil and criminal penalties in federal health care programs), an item or service would be considered "furnished" if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a federal health care program or to whom such payment was made.

Section 1128(c) would also provide that if a person eligible for benefits under Medicare or Medicaid submits a claim for payment for items or services furnished by an excluded individual or entity, and the eligible person did not know or have reason to know that such individual or entity was excluded, then payment must be made for the items or services. In this case, the Secretary must notify the eligible person of the exclusion of the individual or entity, and payment must not be made for items or services furnished by an excluded individual or entity to an eligible person after a reasonable time after this notification.

The section would also provide that if claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than a person eligible for benefits under Medicare or Medicaid or that excluded individual or entity itself, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to the individual or entity that submitted the claim. If a federal health care program contractor provided inaccurate or misleading information resulting in the waiver of an overpayment under this section, the Secretary must take appropriate action to recover the improperly paid amount from the contractor.

Reason for Change

The new provision clarifies current practice.

Effective Date

Date of enactment.

Subtitle C—Enhanced Program and Provider Protections

Sec. 1631. Enhanced CMS Program Protection Authority

Current Law

CMS has implemented regulations requiring providers and suppliers to complete an application to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. CMS reserves the right to perform on-site inspections of a provider or supplier to verify compliance with standards. If enrollment requirements are not met, CMS may revoke Medicare billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. CMS may deny a provider's or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: noncompliance with enrollment requirements, exclusion from participation in Federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application.

CMS manual instructions require that Medicare contractors query the following databases prior to approving an application for enrollment in Medicare: Qualifier.net, the Medicare Exclusions Database (List of Excluded Individuals/Entities or LEIE), and the Government Services Administration (GSA) debarment list. All Medicare contractors are required to query these databases when enrolling providers in the program.

Medicaid beneficiaries may obtain services from any Medicaid participating provider recognized by the state. In addition, Medicaid beneficiaries enrolled in primary care case management system, a Medicaid managed care organization, or similar entities must not restrict the choice of a qualified provider of family planning services and supplies (with some other exceptions). States are not required to provide Medicaid coverage for such services when offered by persons or entities convicted of felonies.

Proposed Law

This provision would add a new section to the SSA, section 1128G that would authorize the Secretary, in cases where there is a significant risk of fraud, to subject providers and suppliers to enhanced screening, oversight, or a moratorium on enrollment. The provision would take effect on January 1, 2011. The Secretary would determine what constitutes a significant risk of fraud by reviewing complaints, reports, referrals from law enforcement or other sources, and the results from data analysis, trend information, or claims review. Risk could be determined with respect to a single category of providers or suppliers or a single category of providers or suppliers operating within a specific geographic area.

This provision would apply to providers or suppliers initially enrolling in Medicare, Medicaid, or CHIP as well as those renewing their enrollment. The Secretary would be authorized to require states to implement these program safeguards as a requirement in their Medicaid or CHIP state plans. State CHIP plans would also be required to include their procedures for enforcing these requirements. Any actions taken or determinations made by the Secretary in imposing these requirements would not be subject to judicial review. Additionally, states would be allowed to conduct enhanced oversight activities beyond those required by the Secretary.

This provision would require the Secretary to establish procedures for screening and enhanced oversight. Screening procedures may include licensing board checks, reviews against the LEIE, background checks, and unannounced pre-enrollment or other site visits. During periods of enhanced oversight (between 30 days and one year) the Secretary would be authorized to take certain actions against providers, including required or unannounced site visits or inspections, prepayment review, enhanced review of claims, and other actions as specified by the Secretary. The Secretary would be allowed to extend these periods to more than one year if necessary.

In instances where the Secretary determines that there is risk of serious ongoing fraud, the Secretary would have the authority to impose a moratorium on enrolling providers within a category of providers and suppliers, including a category within a specific geographic area. Moratoriums could not be imposed if the Secretary makes a determination that the moratorium would adversely impact access to care. Medicaid providers would be prohibited from providing coverage for services delivered by providers under a moratorium.

Reason for Change

The new provision will allow the Secretary to screen providers before they join the program to put in place additional safeguards when there is a heightened risk of waste, fraud, and abuse.

Effective Date

These amendments apply to applications submitted after January 1, 2011.

Sec. 1632. Enhanced Medicare, Medicaid, and CHIP Program Disclosure Requirements Relating to Previous Affiliations

Current Law

In order to receive payment from Medicare, providers must enroll in the Medicare program CMS regulations mandate that enrollment applications contain information necessary to uniquely identify the provider (i.e. proof of business name, social security number, or Tax ID number) and include documentation necessary to verify licensure or eligibility to furnish Medicare covered items or services. Persons who sign the enrollment applications are required to have an ownership or control interest in the provider or supplier. Upon initial enrollment in the program, the signature on the enrollment application must be that of an authorized official. Renewal or updated applications may be signed by a delegated official. CMS has the authority to perform on-site inspections of a provider to

verify enrollment information and determine compliance with Medicare enrollment requirements. CMS has established an internet database called the Provider Enrollment, Chain and Ownership System (PECOS) for providers to submit enrollment information.

Medicaid statute delegates the administration of the Medicaid program to the states. There is considerable variation in how states' administer their provider enrollment processes. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Written agreements require that providers and suppliers maintain specific records, disclose certain ownership information, and grant access to federal and state auditors to books and records.

Proposed Law

Providers or suppliers submitting applications for enrollment or renewing enrollment in Medicare, Medicaid, or CHIP after January 1, 2011 would be required to disclose information related to any current or previous affiliation (within the last 10 years) with providers or suppliers that have uncollected debt, or with persons or entities that have been suspended or excluded, been placed on payment suspension, or had their billing privileges revoked. The Secretary would have the authority to apply program safeguards to providers and suppliers, such as enhanced screening of claims, required or unannounced site visits and inspections, additional reporting requirements, and surety bonds, if the Secretary determines that certain affiliations pose a risk of fraud, waste, and abuse. The provision would also provide the Secretary with the authority to deny enrollment in Medicare, Medicaid, or CHIP in instances when at least one affiliation or affiliations poses a serious risk of fraud, waste or abuse.

Reason for Change

The new provision will allow the Secretary to take into account past affiliations with persons or entities that owe or posed past risk to the program, and will allow the Secretary to take steps to protect the program.

Effective Date

These amendments apply to applications submitted after July 1, 2011.

Sec. 1633. Required Inclusion of Payment Modifier for Certain Evaluation and Management Services

Current Law

Evaluation and management services include certain primary care services, hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

Proposed Law

The provision would require the Secretary to establish a payment modifier for evaluation and management services that result in the ordering of additional services (i.e. lab tests), prescription drugs,

durable medical equipment, or other services determined by the Secretary to be at high risk of fraud, waste, and abuse. The Secretary would be authorized to require providers and suppliers to report the payment modifier on claims.

Reason for Change

The new payment modifier will allow for greater analysis and data collection in areas at risk of fraud and abuse.

Effective Date

Date of enactment.

Sec. 1634. Evaluations and Reports Required Under Medicare Integrity Program.

Current Law

Medicare statute authorizes the establishment of the MIP program. MIP requires the Secretary to enter into contracts with private entities to conduct a variety of program integrity activities for the Medicare program including auditing providers, reviewing claims for medical necessity, and identifying and investigating alleged fraud. MIP was established along with the HCFAC program by HIPAA, which sought to increase and stabilize federal funding for health care anti-fraud activities.

Established by the DRA, the Medicaid Integrity Program is modeled after Medicare's MIP program. The Medicaid Integrity Program provides HHS with dedicated resources to promote Medicaid integrity to contract with entities to reduce fraud, waste, and abuse and to add 100 full-time equivalent staff. Annual reports to Congress on program accomplishments and use of funds are required. In addition, the Secretary is required to develop comprehensive 5–year plans for the program.

Proposed Law

For the contract year beginning in 2011, this provision would require MIP contractors to assure the Secretary that they will conduct periodic evaluations of the effectiveness of their activities. Annual reports would be required to be submitted to the Secretary. A similar provision with respect to the Medicaid Integrity Program would be included in Section 1752 of this bill.

Reason for Change

The new provision will incease the accountability and effectiveness of MIP contractors.

Effective Date

Date of enactment.

Sec. 1635. Require Providers and Suppliers to Adopt Programs to Reduce Waste, Fraud, and Abuse

Current Law

Since 1998, the OIG has been issuing a series of compliance guidance documents for providers participating in federal health care programs to assist in preventing fraud, waste, and abuse. The purpose of the documents is to encourage health care providers to

adopt compliance programs and internal control measures to monitor their adherence to applicable rules, regulations, and requirements. The adoption of these programs is not mandatory. There is no current law explicitly directing health care providers to adopt compliance programs.

Proposed Law

This provision would require providers and suppliers to establish compliance programs to reduce fraud, waste, and abuse. Providers and suppliers that do not meet requirements for establishing these programs would be subject to certain sanctions. The provision would also authorize the Secretary to conduct a pilot program, prior to mandating these requirements to all providers, to test the establishment of compliance programs for providers that the Secretary has determined to be a high risk for fraud, waste, and abuse.

The Secretary, in consultation with the OIG, would be required to establish the core requirements for provider compliance programs. Requirements may include written policies, procedures, and standards of conduct; a designated compliance officer and compliance committee; training and education on fraud, waste and abuse for employees and contractors; a confidential mechanism (i.e. hotline) for receiving compliance questions and reports; guidelines for enforcing standards; internal monitoring and auditing procedures applicable to providers and contractors; and procedures for (1) ensuring prompt responses to detected and potential offenses, (2) developing corrective action initiatives, and (3) returning all identified Medicare, Medicaid, and CHIP overpayments. The Secretary would be required to develop a timeline for the establishment of these requirements and the date by which providers and suppliers would be required to have a compliance program in place.

The CMS Administrator would have the authority to assess whether or not a provider or supplier has met these requirements and impose a CMP of up to $50,000 for each violation. The Secretary would have the authority to impose other intermediate sanctions, such as corrective action plans and additional monitoring, on providers and suppliers for failing to meet these requirements. The provision would also give the Secretary the authority to disenroll a Medicare provider or supplier or impose a CMP or intermediate sanction on any provider or supplier who fails to establish a compliance program.

The provisions of this section would not apply to individual physicians or skilled nursing facilities, although skilled nursing facilities would be required to develop compliance programs under Section 1412 of this Act.

Reason for Change

The new provisions will improve compliance and accountability of Medicare providers and suppliers.

Effective Date

Date of enactment.

Sec. 1636. Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

Current Law

Medicare statute requires that payments only be made, except in certain circumstances, to Medicare eligible providers and only if a written request for payment is filed within three calendar years after the year in which the services were provided. The Secretary is authorized to reduce this period to no less than one year if it deems it necessary for the efficient administration of the program.

As established by CMS regulations, in general, the time limit on submitting a claim for payment is the close of the calendar year after the year in which the services were furnished. For services furnished in the first nine months of the year, claims must be submitted on or before December 31st of the following year. For services furnished in the last three months of a calendar year, claims must be submitted to the contractor on or before December 31st of the second year following the year services were furnished.

Proposed Law

The provision would reduce the time period for filing a written request for payment from three calendar years to one calendar year for services provided under Medicare Parts A and B. The Secretary would have the authority to specify exceptions to this one year period. The provision would eliminate the current statutory requirement that the Secretary must give Medicare Part A and B eligible providers at least one year to submit a claim for payment. The provision would also add a new requirement for MA and PDP plans. Contracts with MA organizations and PDP sponsors would be required to mandate that any provider under contract with, in partnership with, or affiliated with the MA organization or PDP sponsor ensure that a written request for payment be submitted no later than one calendar year after the date the services were furnished. The Secretary would have the authority to specify exceptions to this one year period.

The provision would apply to services furnished on or after January 1, 2011.

Reason for Change

CMS has found that the current 36–month period for filing claims leads to fraudulent gaming of payment systems. Legitimate filers do not need this extended time to file claims—they prefer to receive payment sooner rather than later, while those persons and entities undertaking fraudulent filing will use the long period to watch to see which claims are approved and tailor their filings to reflect that. The reduced time for claims filing will reduce fraudulent claims.

Effective Date

These amendments apply to items and services furnished on or after January 1, 2011.

Sec. 1637. Physicians who Order Durable Medical Equipment or Home Health Services Required to be Medicare Enrolled Physicians or Eligible Professionals

Current Law

Medicare statute defines eligible professional as a physician, certain types of practitioners (i.e. physician assistant, nurse practitioner, clinical social worker, and others), a physical or occupational therapist, qualified speech language pathologist, or a qualified audiologist.

CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. CMS may deny a provider or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: non-compliance with enrollment requirements, exclusion from participation in Federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application.

In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. In the case of home health services, physicians are required to certify that such services were required because the individual was confined to his home and needs skilled nursing care or physical, speech, or occupational therapy; a plan for furnishing services to the individual has been established; and such services were provided under the care of a physician.

In the case of DME, the Secretary is authorized to require, for specified covered items, that payment be made for items and services only if a physician has communicated to the supplier a written order for the item.

Proposed Law

Beginning January 1, 2010, this provision would require physicians who order durable medical equipment or home health services to be a Medicare eligible professional or enrolled in the Medicare program. The Secretary would have the authority to extend these requirements to other Medicare items and services, including covered Part D drugs, based on a determination that such application would help to reduce the risk of fraud, waste, and abuse.

Reason for Change

The new requirement that physicians ordering DME or home health services be Medicare-enrolled will ensure that all physicians prescribing these services undergo the new screening requirements provided in this section, and will reduce waste, fraud, and abuse.

Effective Date

Date of enactment.

Sec. 1638. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse

Current Law

OIG has "permissive" authority to exclude an entity or an individual from a federal health program under numerous circumstances, including failing to supply documentation related to payment for items and services.

Proposed Law

Beginning January 1, 2010 the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services as specified by the Secretary. Medicare providers would be required to maintain and provide access to documentation relating to written orders or requests for payment for DME, certifications for home health services, or referrals for items and services as specified by the Secretary. The provision would also extend the OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to the Secretary to verify payment.

Reason for Change

The new requirement will improve the quality of documentation provided for areas at risk for waste, fraud, and abuse.

Effective Date

These amendments apply to orders, certifications, and referrals made on or after January 1, 2010.

Sec. 1639. Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment under Medicare

Current Law

Home health services are covered under Medicare Parts A and B. In order to receive payment from Medicare, physicians are required to certify and re-certify that specified services (i.e. inpatient psychiatric services, post-hospital extended care services, and home health services) meet certain conditions. In the case of home health services, physicians are required to certify that such services were required because the individual was confined to his home and needs skilled nursing care or physical, speech, or occupational therapy; a plan for furnishing services to the individual has been established; and such services were provided under the care of a physician.

In the case of DME, the Secretary is authorized to require, for specified covered items, that payment be made for items and services only if a physician has communicated to the supplier a written order for the item.

Proposed Law

This provision would require that after January 1, 2010, physicians have a face-to-face encounter (including through telehealth and other than with respect to encounters that are incident to services involved) with the individual prior to issuing a certification or re-certification for home health services or durable medical equipment as a condition for payment under Medicare Parts A and B. The provision would also apply to physicians making home health certifications in Medicaid and CHIP. Physicians must document that they had the face-to-face encounter with the individual during the 6–month period preceding the certification, or other reasonable timeframe as determined by the Secretary.

The Secretary would be authorized to apply the face-to-face encounter requirement to other Medicare items and services based upon a finding that doing so would reduce the risk of waste, fraud, and abuse.

Reason for Change

The new requirement will ensure that a physician oversees the prescription of services in areas of high risk.

Effective Date

These amendments apply to certifications or recertifications made after January 1, 2010.

Sec. 1640. Extension of Testimonial Subpoena Authority to Program Exclusion Investigations

Current Law

Section 1128 of the SSA provides that the Secretary (and through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Exclusion is mandatory for those convicted of certain criminal offenses, and generally the exclusion cannot be for a period of less than five years. OIG also has permissive authority under numerous circumstances to exclude an individual or entity from a federal health program, including the discretion to determine whether and for how long to impose an exclusion.

Proposed Law

The provisions of 205(d) and (e) of the SSA would apply with respect to the Secretary's program exclusion authority. The Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary. The Secretary would also have the ability to delegate this authority to the OIG and the Administrator of CMS for the purposes of a program exclusion investigation. Certain requirements regarding the serving of subpoenas and compensation for subpoenaed witnesses may apply. This section would also provide for judicial enforcement of subpoenas, including in cases where a person refuses to obey a properly served subpoena. This provision would apply to investigations beginning on or after January 1, 2010.

Reason for Change

The new provision will increase the ability of the Secretary to conduct investigations and reduce waste, fraud, and abuse.

Effective Date

These amendments apply to investigations beginning on or after January 1, 2010.

Sec. 1641. Required Repayments of Medicare and Medicaid Overpayments

Current Law

The Secretary is authorized to enter into contracts with private entities to conduct administrative functions, including audits of Medicare participating providers and suppliers to identify alleged overpayments. These entities are generally referred to as Medicare program integrity or MIP contractors.

Medicare statute specifies that identified overpayments to providers or suppliers that are not paid within 30 days of the date of the overpayment determination will accrue interest on the balance of the overpayment at the rate applicable to late payments established by the Secretary of the Treasury. The Secretary is required to enter into repayment plans with providers for which payment within 30 days would constitute a financial hardship. In the case of a provider or supplier for which an overpayment has been identified seeks a reconsideration (the 2nd level of the Medicare appeals process), the Secretary is prohibited from recouping the overpayment until a decision on the reconsideration has been rendered.

Proposed Law

This provision would require the repayment of overpayments identified through an internal audit by Medicare and Medicaid participating providers, including private health plans. The term "overpayment" would be defined as any funds that a person receives or retains under Medicare or Medicaid of which they are not entitled. Person would be defined as any "person" including a provider of services, supplier, Medicaid managed care organization, MA organization, or PDP sponsor. Any person who knows of an overpayment would be required to report and return the overpayment, along with notification for the reason for the overpayment, to the Secretary, the State, an intermediary, a carrier, or a contractor. "Knows," which is referred to as knowing and knowingly in the statute, means that a person with respect to information has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. An overpayment is defined as any finally determined funds that a person receives or retains under Medicare, Medicaid, or CHIP to which the person, after applicable reconciliation is not entitled. The reference to applicable reconciliation in this definition refers to reconciliations procedures that may already be in place for the relevant programs and payments, and is not intended to create any new required reconciliation procedures or rights to reconciliation or appeal. Overpayments would be required to be reported and returned within 60 days of the date of the overpayment determination. Overpayments

returned after the 60 days would create an obligation as defined in section 3729(b)(3) of title 31 of the U.S.C. If it is determined that the reason for the overpayment was related to fraud, repayment would not limit the provider or supplier's liability for additional administrative obligations such as interest, fines, specialties, or civil and criminal sanctions.

Reason for Change

The new requirement will encourage the timely repayment of overpayments.

Effective Date

Date of enactment.

Sec. 1642. Expanded Application of Hardship Waivers for OIG Exclusions to Beneficiaries of any Federal Health Care Program

Current Law

Under section 1128 of the SSA, the Secretary (and, through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs. Exclusions from federal health programs are mandatory under certain circumstances, and permissive in others (i.e., OIG has discretion in whether to exclude an entity or individual). For purposes of section 1128, the term "federal health care program" means (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government other than the health insurance program under chapter 89 of title 5, United States Code (governing health insurance for federal employees); or (2) any State health care program, as defined by the Social Security Act.

Subject to exceptions, in the case of a mandatory exclusion, the minimum period of exclusion cannot be less than five years. However, under section 1128(c)(3)(B) of the Social Security Act, upon the request of a federal health care program administrator who determines that the exclusion would impose a hardship on individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B (or both), the Secretary may waive the exclusion under certain circumstances with respect to that program, in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

Proposed Law

Under section 1128(c)(3)(B) of the SSA, the Secretary would, in accordance with the requirements of the section, be able to waive a mandatory exclusion period where a hardship is imposed on beneficiaries of federal health care programs, in addition to Medicare Part A and Part B beneficiaries.

Reason for Change

The new section increases the ability for the Secretary to use discretion to protect beneficiaries.

Effective Date

Date of enactment.

Sec. 1643. Access to Certain Information on Renal Dialysis Facilities

Current Law

No provision.

Proposed Law

This provision would require End State Renal Disease Facilities to provide the Secretary with access to information relating to any ownership or compensation arrangement between the facility and the medical director of such facility or between the facility and any physician for the purposes of an audit or evaluation.

Reason for Change

The Committee has been very concerned for several years about the financial relationships between medical directors and the dialysis organizations where they serve and the extent to which prescribing decisions are influenced by those financial arrangements or are independent of dosing guidelines, standards, protocols, and algorithms created by dialysis organizations. This authority is necessary so that the OIG may properly investigate these issues.

Effective date

Date of enactment.

Sec. 1644. Billing Agents, Clearinghouses, or Other Alternate Payees Required to Register Under Medicare

Current Law

CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. The enrollment application requires that providers and suppliers include the names, addresses, and tax ID numbers for billing agencies on their applications.

Proposed Law

Beginning January 1, 2012, this provision would require billing agencies, clearinghouses, or other payees that submit claims on behalf of a health care provider to register with the Secretary in a form and manner as determined by the Secretary. A similar provision is put in place with respect to the Medicaid program by section 1759 of this Act.

Reason for Change

By requiring that payees under Medicare are enrolled in the program, these entities will be subject to the enhanced screening procedures established in this section, which will reduce waste, fraud, and abuse in the program.

Effective date

This section applies to claims submitted on or after January 2012.

Sec. 1645. Conforming CMPs to False Claims Act Amendments

Current Law

Section 1128A(a) of the SSA authorizes the imposition of CMPs on any person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs. Under 1128A(a)(1), CMPs may be imposed on any person who knowingly presents or causes to be presented to certain government officers, employees, agents, or agencies certain false or fraudulent claims for items or services. As defined by section 1128A(i), an item or service is defined to include any particular item, device, medical supply, or service purportedly provided to a patient and listed in an itemized claim for payment. A claim is defined by this section as an application for payments for items and services under a federal health care program.

Section 1128A generally provides for monetary penalties of up to $10,000 for each item or service claimed, and $15,000 or $50,000 under other circumstances, as well as additional assessments. Under Section 1128(a)(4), certain persons excluded from participating in Medicare or a State health care program who retain a direct or indirect ownership or control interest in an entity that is participating in Medicare or a State health care program and know or should know of the action constituting the basis for the exclusion, or who are an officer or managing such an entity, may be subject to civil penalties.

Section 1128A(c)(1) of the SSA provides that the Secretary may initiate a proceeding to determine whether to impose a civil monetary penalty, assessment, or exclusion under the section only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place.

The federal False Claims Act (FCA), codified at 31 U.S.C. §§3729–3733, provides for judicial imposition of CMPs and damages for the knowing submission of false claims to the United States government. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA), P.L. 111–21, made several amendments to the False Claims Act that, according to legislative history, were intended to clarify the meaning of several provisions of the FCA in light of judicial interpretations of the statute that were said to run contrary to congressional intent and limit the scope of the law. Among the changes made by FERA, the Act removed a requirement under 30 U.S.C. 3729(a)(1) that provided that in order for liability to attach, a false claim must be presented "to an officer or employee of the United States Government or a member of the Armed Forces of the United States." In addition, FERA expanded the definition of the term "claim" to include "any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that . . . is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest,

and if the Government provided or has provided any portion of the money or property requested or demanded . . .".

Proposed Law

Similar to FERA, the bill would amend section 1128A(a)(1) to remove the requirement for presentment of a claim to a government officer, employees, agents, or agencies in order to be liable for CMPs. The bill would also expand the reach of section 1128A(a)(4), under which a person excluded from participating in a federal health care program (in addition to Medicare or a State health care program) who retains ownership in an entity participating in the program, or is an officer or managing employee of such an entity, would be subject to CMPs. The bill would create a new section 1128A(a)(12), which would impose CMPs on a person who conspires to commit a violation of section 1128A. Persons violating section 1128A(a)(12) would be subject to a $50,000 penalty for violations of the section and an additional assessment of no more than three times the total amount that would otherwise apply. In addition, a new section 1128A(a)(13) would provide that a person who knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a federal health care program can be subject to CMPs. Penalties under this section would be $50,000 for each false record or statement, concealment, avoidance, or decrease. Persons would also be subject to an assessment of no more than three times the total amount of the obligation under certain circumstances.

Under section 1128A(c)(1), the Secretary could initiate a proceeding to determine whether to impose a civil monetary penalty, assessment, or exclusion for an occurrence up to ten years, instead of six, after the occurrence took place.

The bill would also amend certain definitions in section 1128A(i). For example, under 1128(i)(2), the definition of a claim would be broadened to include any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a federal health care program, whether or not the United States or a State agency has title to the money or property, that is presented or caused to be presented to a government officer, employee, agent or agency. A claim under this section would also include applications, requests, or demands made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the federal health care program's behalf or to advance a federal health care program interest, and if the federal health care program (1) provides or has provided any portion of the money or property requested or demanded; or (2) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded. In addition, an "item or service" would include, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a federal health care program.

Reason for Change

The changes ensure consistency with amendments made recently to the False Calims Act.

Effective date

Date of enactment.

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

Sec. 1651. Access to Information Necessary to Identify Waste and Abuse

Current Law

Statutory offices of inspectors general (OIG) consolidate responsibility for audits and investigations within a federal agency. The Inspector General Act of 1978 and its amendments of 1988 granted inspectors general substantial independence and powers to carry out their mandate to combat waste, fraud, and abuse. In carrying out their functions, IGs have relatively unlimited authority, including subpoena power, to access all records and information of an agency.

Every contract with a PDP or MA-PD (Medicare Advantage Prescription Drug Plan) is required to provide the Secretary with the right to inspect and audit any books and records of the plan related to costs. Information obtained or disclosed during an audit may be used by officers, employees, and HHS contractors for the purposes of conducting the audit only.

Proposed Law

The provision would establish that the Attorney General have access to all Medicare and Medicaid claims and payment databases facilitated by the OIG and in consultation with CMS or the owner of any such database. Access would be required to be carried out for the purposes of law enforcement activity and in a manner consistent with any applicable disclosure, privacy, and security laws, including the HIPAA and Privacy Act of 1974, and subject to any statutory information systems security requirements in statute or mandated by the Secretary.

Reason for Change

The provision clarifies access to Medicare and Medicaid claims and payment database in order to facilitate investigations and enforcement, and reduce waste, fraud, and abuse.

Effective date

Date of enactment.

Sec. 1652. Elimination of Duplication Between the Healthcare Integrity and Protection Databank and the National Practitioner Databank

Current Law

Medicare statute requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of adverse actions taken against health care pro-

viders or suppliers. The OIG issues regulations implementing the Health Care Integrity and Protection Data Bank (HIPDB). The statute requires the following types of health care related adverse actions be reported—civil judgments, federal or state criminal convictions, actions taken by federal or state licensing agencies, and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Both federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of $25,000. The Secretary is authorized to charge fees to access information in the database. However, fees cannot apply to requests from federal entities. HIPDB cannot duplicate the reporting requirements established for the National Practitioner Data Bank.

Title IV of the Health Care Quality Improvement Act of 1986, as amended, established the National Practitioner Data Bank (NPDB). The NPDB collects and releases data related to the professional competence of physicians, dentists, and certain healthcare practitioners. The types of information included in the NPDB are medical malpractice payments, certain adverse licensure actions, adverse clinical privileging actions, adverse professional society membership actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a civil monetary penalty. Section 1921 of the Social Security Act expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by State licensing and certification agencies, peer review organizations, and private accreditation organizations. Section 1921 also required that actions taken against all health care practitioners be included in the databank. States are required to have a system for reporting adverse actions to the NPDB. Both databases are overseen by the Health Resources and Services Administration (HRSA) within HHS.

Proposed Law

Upon enactment of this Act, this provision would require the Secretary to establish a process to terminate the HIPDB. The Secretary would be required to ensure that the information that was formerly collected in the HIPDB is transferred to the NPDB. Requirements pertaining to the establishment of the HIPDB, such as rules for reporting information, the types of information that are reported, and rules for disclosure, would all apply to the NPDB upon termination of the HIPDB. The provision would eliminate the OIG's responsibility for reporting adverse actions to the database. After the Secretary certifies that the transition of information from the HIPDB to the NIPD is complete, any fees charged by the Secretary for access to the database would apply to federal agencies. The Department of Veterans Affairs (VA) would be exempted from these charges for one year. The transition would be funded from the fees collected to access the database and from additional amounts as necessary from the annual HCFAC appropriation avail-

able to the Secretary and the OIG. Funding would be available for one year after the enactment date of this legislation.

Reason for Change

The section establishes a timeline for the process already underway of consolidating databases. This will ensure the efficient use of resources and greater access to data necessary for preserving program integrity.

Effective date

Upon certification by the Secretary according to the provision or the first day of the second year after enactment.

Sec. 1653. Compliance with HIPAA Privacy and Security Standards

Current Law

The HIPAA Privacy and Security Rules were promulgated by HHS pursuant to sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to establish national standards for the privacy and security of protected health information.

The HIPAA Privacy and Security Rules apply primarily to covered entities—health plans, health care clearinghouses, and health care providers who transmit financial and administrative transactions electronically. Failure to comply with these regulations may result in civil or criminal penalties for covered entities. The HITECH Act, enacted as part of the American Recovery and Reinvestment Act, extends civil and criminal liability to business associates of covered entities for violations that occur on or after February 17, 2010. Business associates are defined as persons who perform, or assist in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity. Examples of business associates include persons who perform legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

The HIPAA Privacy Rule governs the disclosure of protected health information (PHI)—that is, individually identifiable health information "created or received by a [covered entity]" that "[r]elates to the . . . health or condition of an individual" or to the provision of or payment for health care. A covered entity is permitted to use or disclose PHI without patient authorization for treatment, payment, or health care operations. For other purposes, a covered entity may only use or disclose PHI with patient authorization subject to certain exceptions. Exceptions permit the use or disclosure of PHI without patient authorization or prior agreement for public health, judicial, law enforcement, and other narrow purposes. The HIPAA Privacy Rule also requires covered entities and business associates to provide an accounting of certain disclosures; to make reasonable efforts to disclose only the minimum information necessary; to safeguard PHI from inappropriate use or disclo-

sure; and to provide a notice of their privacy practices. Individuals also have a right to review and obtain copies of their PHI and to request corrections.

The HIPAA Security Rule, applies only to PHI in electronic form (EPHI), and requires a covered entity or business associate to maintain administrative, technical, and physical safeguards to ensure the confidentiality, integrity, and availability of all EPHI the covered entity creates, receives, maintains, or transmits.

The HITECH Act will also impose a breach notification requirement that is triggered when unsecured PHI or EPHI is compromised. This requirement is applicable to both covered entities and business associates and will become effective 30 days after HHS issues final regulations implementing this requirement.

The Privacy Act of 1974 generally prohibits disclosures of records contained in a system of records maintained by a federal agency without the written request or consent of the individual to whom the record pertains. A system of records is a group of records under the control of an agency from which information is retrieved by the name of the individual or by some identifier assigned to the individual, such as a Social Security Number. The Privacy Act contains certain statutory exceptions, and a list of agency systems of records, including the routine uses of those records, is published in the Federal Register.

Proposed Law

The provision would mandate compliance with HIPAA privacy and security requirements and the Privacy Act of 1974 in carrying out the provisions of this subtitle.

Reason for Change

The provision clarifies that all provisions must protect privacy and security as outlined in HIPAA.

Effective date

Date of enactment.

TITLE VII—MEDICAID AND CHIP

(Not Within the Jurisdiction of the Committee on Ways and Means)

TITLE VIII—REVENUE-RELATED PROVISIONS

A. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS

(Sec. 1801 of the bill and Sec. 6103(0(19) of the Code)

PRESENT LAW

Outreach efforts to increase awareness of the availability of Part D subsidies for low-income individuals

Under Medicare Part D (the prescription drug program), beneficiaries with incomes and assets below certain levels may be eligible for Low Income Subsidy ("LIS") benefits. Section 1144 of the So-

cial Security Act requires the Commissioner of Social Security to conduct outreach efforts to inform potential LIS beneficiaries about the additional premium and cost-sharing subsidies. The Social Security Administration ("SSA"), from its own records and other nontax records available to SSA, is able to determine a potential pool of LIS beneficiaries, but such pool includes many persons ineligible for the LIS benefits due to excess income or resources.

For example, prior to the beginning of the Part D program, SSA identified and conducted outreach to 18.6 million potentially eligible individuals; of these, 6.2 million applied by March 2007 and 2.2 million were found to be eligible. The Centers for Medicare and Medicaid Services ("CMS") believes that some of the remaining 12.4 million that did not apply could be eligible for LIS benefits. The SSA has contacted these individuals a number of times, but has had limited success identifying additional potentially eligible individuals and securing applications from them.

Confidentiality of returns and return information

Section 6103 provides that returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information except as provided in the Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances.

For example, the Code provides for the disclosure of returns and return information to the SSA for several nontax administration purposes. For purposes of administering the Social Security Act, section 6103(1)(1)(A) authorizes the disclosure to the SSA of returns and return information relating to self-employment taxes, Federal Insurance Contributions Act taxes, and taxes withheld at the source on wages.[174] Section 6103(1)(5) provides for the disclosure to the SSA of certain information returns for purposes of carrying out an effective return processing program, the Combined Annual Wage Reporting Program, and for providing mortality status of individuals for certain epidemiological and similar research.[175] In addition, the Code provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B Premium Subsidy Adjustment.[176]

A December 2008 Treasury study conducted jointly with the SSA found that certain income information in IRS's possession, and,

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[174] Documents which may be disclosed under this provision include but are not limited to:
- Schedule C, Form 1040, *Profit (or Loss) from Business or Profession*
- Schedule E, Form 1040, *Supplemental Income Schedule-Part 111, Income or Loss from Partnerships*
- Schedule F, Form 1040, *Farm Income and Expenses*
- Schedule SE, Form 1040, *Computation of Social Security Self-Employment Tax*
- Form 1065, *U.S. Partnership Return of Income*
- Form 941, *Employer's Quarterly Federal Tax Return*
- Form 942, *Employer's Quarterly Tax Return for Household Employees* or portions Schedule H, Form 1040
- Form 943, *Employer's Annual Tax Return for Agricultural Employees*
- Form W–2, *Wage and Tax Statement.*

See Internal Revenue Service, Internal Revenue Manual, sec. 11.3.29.3—Administration of the Social Security Act—Social Security Administration (May 27, 2005).

[175] The information returns that may be disclosed under section 6103(1)(5) are those filed under Part Subchapter A, Chapter 61 of the Code. These include, primarily, Form W–2, Form W–3, and Form 1099–R. See Internal Revenue Service, Internal Revenue Manual, sec. 11.3.29.3.2—Disclosure of Information Returns to Social Security Administration (May 27, 2005).

[176] Sec. 6103(1)(20).

through imputation, some asset information, could be used to narrow the pool of potentially eligible LIS beneficiaries identified by the SSA, thereby allowing the SSA to better target its outreach efforts. Specifically, tax information could be used to screen out some individuals whose income or resources make them likely to be ineligible for LIS benefits.[177]

REASONS FOR CHANGE

The Committee believes additional income and asset information will assist the SSA in narrowing the pool of identified individuals by excluding those persons likely to ineligible for LIS benefits. With a narrower pool, the SSA could better target its future efforts toward those individuals more likely to be eligible and not expend resources contacting persons that tax records indicate are probably ineligible for LIS benefits.

EXPLANATION OF PROVISION

Under the provision, upon written request from the Commissioner of Social Security, officers and employees of the SSA will have access to the following information (including information available under sections 6103(l)(1) and (l)(5)) with respect to any individual identified by the Commissioner of Social Security:

1. return information for the applicable year from returns with respect to wages and payments of retirement income;
2. unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year;
3. if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self employment on such return;
4. if the taxpayer's return status was married filing separately, the social security number of the taxpayer's spouse;
5. if the taxpayer filed a joint return, the social security number, unearned income information, and income information from partnerships, trusts, estates, and Subchapter S corporations of the taxpayer's spouse; and
6. such other return information relating to the taxpayer (and, in the case of a joint return, the taxpayer's spouse) as is prescribed by the Secretary by regulation as might indicate that the taxpayer is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

For purposes of the provision, "applicable year" means the most recent taxable year for which information is available in the IRS's taxpayer information records. Under the provision, the SSA may only request tax information with respect to individuals the SSA has identified, through the use of all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy. In the case of an identified individual whose return status was married filing separately and

[177] Department of the Treasury, Office of Tax Analysis, Value of IRS Information for Determining Eligibility for the Low Income Subsidy Program (LIS) of the Medicare Prescription Drug Program (Medicare Part D) (December 2008) at 1 and 3.

whose spouse was not identified by the SSA as likely to be eligible for a low-income prescription drug subsidy, the SSA may make a separate request for information related to such spouse.

The information disclosed under the provision can only be used by the SSA for purposes of identifying those individuals likely to be ineligible for a low-income prescription drug subsidy for purposes of its outreach efforts under section 1144 of the Social Security Act.

EFFECTIVE DATE

The provision is effective for disclosures made after the date that is 12 months after the date of enactment.

B. COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND

(Sec. 1802 of the bill and new Secs. 4375, 4376, 4377, and 9511 of the Code)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The Committee believes that comparative effectiveness research is a public good and that a sustained investment in such research is needed to improve the quality of information about the relative strengths and weaknesses of various health care items, services and systems to allow physicians and patients to make more informed health care decisions. To ensure that there are sufficient amounts of public and private funds dedicated to this purpose, and to insulate such funding from inappropriate outside influence, the Committee believes that it is appropriate to establish a trust fund, impose fees on health insurance plans and receive transfer payments from Medicare, and have such amounts in the fund dedicated to finance comparative effectiveness research.

EXPLANATION OF PROVISION

In general

The provision establishes the Health Care Comparative Effectiveness Research Trust Fund ("CERTF") to carry out the provisions in the bill relating to comparative effectiveness research.

The following amounts are appropriated to the CERTF: $90,000,000 for fiscal year 2010; $100,000,000 for fiscal year 2011; and $110,000,000 for fiscal year 2012. For each fiscal year beginning with fiscal year 2013, the amount appropriated to the CERTF is (1) an amount equal to the net revenues received in the Treasury from the fees imposed on health insurance and self-insured plans under new Code sections 4375, 4376 and 4377 for such fiscal year, and (2) amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount for the fiscal year multiplied by the average number of individuals entitled to benefits under Medicare part A, or enrolled under Medicare part B, for such fiscal year. The amount transferred under (2) is limited to $90,000,000. Net revenues means the

amount, as estimated by the Secretary of the Treasury, equaling the excess of the fees received in the Treasury on account of the new fee on health insurance and self-insured plans under new Code sections 4375, 4376 and 4377, over the decrease in tax imposed by chapter one of the Code relating to the fees imposed by such sections.

The amounts appropriated for fiscal years 2011 through 2013, as well as the amounts transferred under (2), above, are to be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, and from the Medicare Prescription Drug Account within such Trust Fund, in proportion to the total expenditures during such year that are made under Medicare for the respective trust fund or account.

The fair share per capita amount is an amount computed by the Secretary of Health and Human Services for such fiscal year that will result in revenues to the CERTF of $375,000,000 for the fiscal year. If the Secretary is unable to compute the fair share per capita amount for a fiscal year, a default amount is used. The default amount is $2 for fiscal year 2013. For a subsequent year, the default amount is equal to the default amount for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index for the 12–month period ending with April of the preceding fiscal year. Beginning not later than December 31, 2011, the Secretary of Health and Human Services must submit to Congress an annual recommendation for a fair share per capita amount for purposes of funding the CERTF.

At least the following amounts in the CERTF must be available to carry out the activities of the Comparative Effectiveness Research Commission established under the bill: $7,000,000 for fiscal year 2010; $9,000,000 for fiscal year 2011; and $10,000,000 for each fiscal year beginning with 2012.

Financing CERTF from fees on health plans

As discussed above, the CERTF is funded in part from fees imposed on health plans under new Code sections 4375 through 4377. Under the provision, a fee is imposed on each specified health insurance policy equal to the fair share per capita amount multiplied by the average number of lives covered under the policy. The issuer of the policy is liable for payment of the fee. A specified health insurance policy includes any accident or health insurance policy[178] issued with respect to individuals residing in the United States.[179] An arrangement under which fixed payments of premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, is treated as a specified health insur-

[178] A specified health insurance policy does not include insurance if substantially all of the coverage provided under such policy consists of excepted benefits described in section 9832(c) of the Code. Examples of excepted benefits described in section 9832(c) are coverage for only accident, or disability insurance, or any combination thereof; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; limited scope dental or vision benefits; benefits for long term care, nursing home care, community based care, or any combination thereof; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental coverage.

[179] Under the provision, the United States includes any possession of the United States.

ance policy. The person agreeing to provide or arrange for the provision of coverage is treated as the issuer.

In the case of an applicable self-insured health plan, a fee is imposed equal to the fair share per capita amount multiplied by the average number of lives covered under the plan. The plan sponsor is liable for payment of the fee. For purposes of the provision, the plan sponsor is: the employer in the case of a plan established or maintained by a single employer or the employee organization in the case of a plan established or maintained by an employee organization. In the case of (1) a plan established or maintained by two or more employers or jointly by one of more employers and one or more employee organizations, (2) a multiple employer welfare arrangement, or (3) a voluntary employees' beneficiary association described in Code section 501(c)(9), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. In the case of a rural electric cooperative or a rural telephone cooperative, the plan sponsor is the cooperative or association.

Under the provision, an applicable self-insured health plan is any plan providing accident or health coverage if any portion of such coverage is provided other than through an insurance policy if such plan is established or maintained (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a voluntary employees' beneficiary association described in section 501(c)(9) of the Code, (5) by any organization described in section 501(c)(6) of the Code, or (6) in the case of a plan not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 ("ERISA")), a rural electric cooperative (as defined in section 3(40) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

Governmental entities are not exempt from the fees imposed under the provision except in the case of certain exempt governmental programs. Exempt governmental programs include Medicare, Medicaid, SCHIP, and any program established by Federal law for providing medical care (other than through insurance policies) to members of the Armed Forces, veterans, or members of Indian tribes.

No amount collected from the fee on health insurance and self insurance plans is covered over to any possession of the United States. For purposes of the procedure and administration rules under the Code, the fee imposed under the provision is treated as a tax.

EFFECTIVE DATE

The fee on health insurance and self-insured plans is effective with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

Sec. 1901. Repeal of the Trigger Provision

Current Law

The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees which reports annually to Congress. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173, MMA), Subtitle A of title VIII requires the trustees' report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenue financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds). MMA requires that if an excess general revenue funding determination is made for two successive years, the President must submit a legislative proposal to respond to the warning. The Congress is required to consider the proposals on an expedited basis. However, passage of legislation within a specific time frame is not required. On January 6, 2009, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for the 111th Congress.

Proposed Law

The trigger provision would be repealed.

Reason for Change

The 45 percent threshold is an artificial and misleading measure of Medicare's fiscal health. Its continuation builds a case for unnecessary and radical changes to the Medicare program and makes it more difficult to address any future funding shortfalls.

Effective date

Date of enactment.

Sec. 1902. Repeal of the Comparative Cost Adjustment (CCA) Program

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173, MMA) requires the Secretary to establish a program for the application of comparative cost adjustment (CCA) in CCA areas beginning in 2010. The six-year program will begin January 1, 2010, and end December 31, 2015. The program is designed to test direct competition among local MA plans, as well as competition between local MA plans and fee-for-service Medicare. This program will occur only in a limited number of statutorily qualifying areas in the country.

The benchmark for MA local plans in a CCA area will be calculated using a formula that weights (1) the projected FFS spending in an area (with certain adjustments for demographics and health status) and (2) a weighted average of plan bids.

For Medicare beneficiaries in traditional Medicare, Part B premiums in CCA areas will be adjusted either up or down, depending on whether the FFS amount is more or less than the CCA area benchmark. If the FFS amount is greater than the benchmark, beneficiaries in traditional Medicare FFS will pay a higher Part B premium than other FFS beneficiaries in non-CCA areas. If the FFS amount is less than the benchmark, the Part B premium for FFS beneficiaries will be reduced by 75% of the difference. These increases and decreases are subject to a 5% limit; that is, adjustments to Part B premiums in CCA areas cannot exceed 5% of the national part B premium. Beneficiaries in traditional Medicare FFS with incomes below 150% of poverty, who qualify for low-income subsidies under the Medicare prescription drug program, will not have their Part B premium increased.

Proposed Law

The provision would repeal the comparative cost adjustment program.

Reason for Change

The CCA is an ideological attempt to fundamentally change Medicare from an entitlement to benefits to a defined contribution program. This concept was rejected by the Bipartisan Commission on the Future of Medicare in 1999.

Effective date

Date of enactment.

Sec. 1903. Extension of Gainsharing Demonstration

Current Law

Section 5007 of the Deficit Reduction Act of 2005 (P.L.109–171; DRA) authorizes a gainsharing demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and the efficiency of care provided to beneficiaries. In the absence of this DRA authority, gainsharing arrangements are restricted by the Civil Monetary Penalty law. CMS is operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and will end as mandated on December 31, 2009. The Secretary was required to submit a report on quality improvement and achieved savings as a result of the demonstration no later than December 1, 2009. The final report on these issues was due on May 1, 2010. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010.

Proposed Law

The authority to conduct the gainsharing demonstration would be extended until September 30, 2011. The due date of the quality improvement and achieved savings report would be extended from December 1, 2009, to March 31, 2011. The final report would be due March 31, 2013, instead of May 1, 2010. An additional $1.6 million would be appropriated in FY2010. All appropriations would be available for expenditure through FY201.

Reason for change

A key issue with many hospital-focused pay-for-performance initiatives is that physicians—crucial to generating changes in hospital care—often do not participate in the financial rewards of a hospital's quality improvement efforts. The hospitals can increase quality improvement with close collaboration of physicians by reducing adverse events and reducing length of stay. The gainsharing demonstration project authorized in the DRA was delayed in its start by 21 months. This provision allows for completion of the project so Congress can have a full evaluation report on the arrangements between hospitals and physicians in the context of quality improvement and cost-control.

Sec. 1904. Grants to States for Quality Home Visitation Programs for Families with Young Children and Families Expecting Children

HOME VISITATION

Current Law

Title IV–B of the Social Security Act authorizes formula grants to states, territories and tribes for the provision of a range of child and family services. Those services are generally intended to improve children's safety, ensure them a permanent home, and, overall, support the well-being of children and their families. Subpart 1 authorizes the Stephanie Tubbs Jones Child Welfare Services program. Subpart 2 authorizes the Promoting Safe and Stable Families program. Both programs are administered at the federal level by the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services (HHS). To receive funds under these programs states are required to submit state plans and to meet multiple requirements related to how the funds are used, including provision of certain protections for children in foster care (Subpart 1); expenditures of "significant" portions of funds for each of four broad categories of services to children and families: family support, family preservation, time-limited reunification, and adoption promotion and support (Subpart 2), and limits on spending for administrative purposes (both subparts). States must provide no less than 25% of the total program funding for child and family services under both of these programs.

Title IV–B of the Social Security Act also authorizes funds for competitive grants to eligible entities to support child welfare related research and demonstration activities and Family Connections grants (Subpart 1) as well as Mentoring Children of Prisoners grants (Subpart 2). Funds appropriated for these purposes are also administered by HHS/ACF.

Proposed Law

Would create a new Subpart 3 of Title IV–B of the Social Security Act to provide funds to states, territories and tribes for the establishment and expansion of voluntary home visitation programs for families with young children (under school age) and families expecting children. The purpose of this support would be to improve the well-being, health, and development of children. The bill would appropriate a total of $750 million for this purpose over five years,

as follows: $50 million for FY2010; $100 million for FY2011; $150 million for FY2012; $200 million for FY2013; and $250 million for FY2014.

State Application and Reporting Requirements: To receive a grant, states, territories, and tribes would be required to submit an application containing:

- A description of the programs to be supported, outcomes intended to be achieved and evidence to support effectiveness of the programs;
- Results of a statewide needs assessment detailing current-services, sources and amount of funding provided to these programs, capacity of home visitation programs, gaps in services, and training and technical assistance offered to support goals of current program;
- An assurance that the state will identify and give priority to funding home visitation programs serving high-need communities;
- An assurance that the state will reserve 5% of funding for training and technical assistance;
- An assurance that the state will promote coordination and collaboration with other home visitation programs, child and family services, health services, and income supports, and other related assistance; and will support programs that provide referrals to other programs serving children and families, as appropriate;
- An assurance that the state will submit an annual report to HHS describing services delivered by programs funded under this grant; and
- An assurance that the state will cooperate with a national independent evaluation of the home visitation program conducted by HHS (or by another entity under contract with or via a grant from HHS).

Maintenance of Effort: Beginning with FY2011, a state would not be eligible for these funds unless HHS determines that the state's spending (i.e., aggregate expenditures from state and local sources) for home visitation programs serving families with young children or those expecting children was no less in the immediately preceding fiscal year than in the second preceding fiscal year. (For example, for a state to receive FY2011 funding, HHS would need to find that the state's spending for home visitation in FY2010 was no less than it had been in FY2009; for a state to receive this home visitation funding in FY2012 funding, HHS must find that the state's home visitation spending in FY2011 was no less than it had been in FY2010, etc.)

Payments to States and Territories and State Match: HHS must make a grant to each state, territory, or tribe that submits an application meeting the specified requirements, provided that the state also meets the applicable maintenance of effort requirement. A state is entitled to an annual allotment of funds under this program that is equal to the amount appropriated for the home visitation program in a given year (minus funds reserved for training and technical assistance and for tribal home visitation programs) multiplied by the state's relative share of all children in the nation who are living in families with income at or below 200% of the federal poverty line. From the available allotments for a given year,

the Secretary would award grants in an amount equal to the reimbursable percentage of the eligible expenditures for the state in a given year. The reimbursable percentage would be equal to 85% for FY2010; 80% for FY2011, 75% for FY2010 and any succeeding fiscal year.

States may not use any federal funds to meet the state share of total spending. Any federal funds that a state certifies to HHS that it will not use may be re-allotted to other states.

Eligible Expenditures: To be eligible for federal reimbursement, a state's home visitation expenditures would need to be used only in support of voluntary home visitation programs for families with children under the age of entry to school or for families expecting children—provided those programs met certain criteria—and for training, technical assistance, and evaluations related to those programs. Also if a state had claimed reimbursement for a home visitation expenditure under another provision of federal law it could not also claim that expenditure for reimbursement under the home visitation program.

Finally the bill provides that a declining share of expenditures for home visitation programs that do not meet the "strongest evidence of effectiveness" may be claimed as eligible expenditures. Specifically no more than 60% of a state's total eligible home visitation expenditures in FY2010 may be for programs that do not meet the strongest level of evidence and this share declines by 5 percentage points each year until it reaches 40% in FY2014.

Evaluation, Training and Technical Assistance: Five percent of federal funding for the program ($2.5 million, FY2010; $5.0 million, FY2011; $7.5 million, FY2012; $10.0 million, FY2013; and $12.5 million, FY2014) must be reserved by HHS for—

- training and technical assistance to states, including dissemination of best practices in early childhood home visitation; and
- an independent evaluation (conducted by HHS, or by another entity under grant or contract with HHS) of the effectiveness of home visitation programs funded under this program.

Tribal home visitation programs: After making reservation for evaluation, training and technical assistance, 3% of remaining funds are to be reserved for tribal home visitation programs ($1.425 million, FY2010; $2.850 million, FY2011; $4.275 million, FY2012; $5.700 million, FY2013; $7.125 million, FY2014). The amount appropriated for tribal home visitation programs in a given year would be distributed based on a formula that takes into account the tribe's relative share of all children in all Indian tribes who are living in families with income at or below 200% of the federal poverty line. Tribes must meet all of the grant application requirements and eligible expenditure rules made of states. However, HHS, generally, may waive or modify any other requirement for receipt of these home visitation funds, including the maintenance of effort requirement. For purposes of this program Indian tribes are defined to include any tribe, band, nation, or organized group or community of Indians that is federally recognized and for which there is a reservation (including Indian reservations, former Indian reservations in Oklahoma, and public domain Indian allotments), or any Alaska Native organization that is eligible to operate a fed-

eral program under the Indian Self-Determination and Education Assistance Act.

State Reports and Reports to Congress: State's receiving grants for nurse home visitation programs under this provision would be required to submit an annual report to the Secretary of HHS on the progress made by State in improving the well-being, health, and development of children through nurse home visitation programs. HHS would be required to provide an interim report on the independent evaluation of the home visitation program within three years of enactment of the home visitation program and a final report on the evaluation within five years. Further, HHS would be required to submit a report to Congress, annually, on activities carried out with funds provided under the home visitation program.

Sec. 1905. Improved Coordination and Protection for Dual Eligibles

Current Law

There are no specific provisions in current law for coordination and protection of dual eligibles.

Proposed Law

The Secretary would be required to create an identifiable office or program within the Centers for Medicare and Medicaid Services (CMS) to improve coordination between Medicare and Medicaid and to improve protections for dual eligibles. Dual eligibles would be defined as individuals eligible for both Medicare and Medicaid and would include those individuals who are eligible for benefits under the Medicare Savings Program (MSP). The CMS office or program would: (1) review Medicare (Parts A, B, and C) and Medicaid policies on enrollment, benefits, service delivery, payment, and grievance and appeals processes; (2) identify areas of Medicare and Medicaid policies where better coordination or protection could improve care and reduce costs for duals; (3) issue guidance to states on how to improve coordination and protection for dual eligibles.

The elements of improved coordination and protection would include efforts (1) to simplify dual eligibles' access to benefits and services under Medicare and Medicaid, (2) to improve care continuity for dual eligibles and ensure safe and effective care transitions, (3) to harmonize regulatory conflicts between Medicare and Medicaid rules affecting dual eligibles, and (4) to improve Medicare and Medicaid's combined total cost and quality performance for dual eligibles.

The Secretary's responsibilities for implementing the CMS office or program for coordination and protection for dual eligibles would include: (1) examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care; (2) development of methods to facilitate dual eligibles' access to post-acute and community-based services and to identify actions to improve coordination of community-based care; (3) a study of enrollment in MSP (for both Medicare and Medicaid) to identify methods to more efficiently and effectively reach and enroll dual eligibles; (4) an assessment of communication strategies aimed at dual eligibles, including the Medicare website, 1–800–MEDI-

CARE, and the Medicare handbook; (5) research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors relating to enrollee satisfaction with services and delivery; (6) collection and dissemination to the public of data and a database that describes eligibility, benefits, and cost-sharing assistance available to dual eligibles by state; (7) monitoring total combined Medicare and Medicaid program expenditures in serving dual eligibles and making recommendations to optimize total quality and cost performance across both programs; and (8) coordination of Medicare Advantage plan activities under Medicare and Medicaid.

Within one year after enactment of this provision and then every three years thereafter, the Secretary would be required to submit a report to Congress on the progress in improving coordination and protection for dual eligibles as described in this provision.

Reason for Change

Individuals who become dually eligible for Medicare and Medicaid—through age, disability or low income—are among the frailest and sickest beneficiaries. These nearly 9 million individuals are more likely than other Medicare beneficiaries to have low incomes, be disabled or in poor health, lack a high school diploma and live in an institution. Dual eligibles are more likely than non-dually eligible Medicare beneficiaries to have a mental illness—33% of duals compared with 15% of non-duals are living with a mental illness—and have higher rates of diabetes, pulmonary disease, stroke and Alzheimer's disease. These characteristics lead to high utilization and spending; in a year, 26% of dual eligibles had an inpatient hospital visit, compared with 16% of non-duals, and per capita spending on dual eligibles' medical care is nearly five times higher than spending on non-dual eligibles.

Medicare is the primary payer for dual eligibles' health care and Medicaid fills in the gaps, including paying for Medicare premiums and cost sharing, and covering certain services not included in the Medicare benefit (e.g., long-term care). Though dual eligibles are served by both programs, there is very little coordination between Medicare and the 50 state Medicaid programs to ensure that individuals' health needs are covered and services are coordinated. Furthermore, policy discussions around Medicare and Medicaid often occur in isolation, with little regard for coordinating the two programs. The Committee is concerned about this lack of coordination because of the serious implications it can have both for dual eligibles' access to quality health care, and on spending in both programs. MedPAC has found that the current arrangement creates incentives for cost shifting between the programs and may be detrimental to quality care and access.

The Committee believes that a dedicated office or program within CMS will allow for true program coordination between policymakers. The act specifies many areas which the Committee expects that coordination between programs would improve dual eligibles' quality of care and may decrease costs to both programs, including outreach and communication policies, access to post-acute and community-based care and increased data collection and dissemination. Regular reports to the Congress will ensure that the Congress is

informed as to the progress made under this section and can take appropriate legislative actions.

Effective Date

Date of enactment.

Sec. 1906. Assessment of Medicare Cost-Intensive Diseases and Conditions

Current Law

No provision.

Proposed Law

The CMS Administrator would conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program. The assessment would inform research priorities within HHS in order to improve the prevention, or treatment or cure, of such diseases and conditions. Not later than January 1, 2011, the Administrator would submit the report to the Secretary of Health and Human Services and the Secretary would transmit the report to the Congress.

Not later than January 1, 2013, and biennially thereafter, the CMS Administrator would review and update the assessment described above and make such recommendations to the Secretary on changes in research priorities as appropriate. The Secretary would submit a report on such recommendations to the Congress.

A new fund would be established in the Treasury of the United States, to be known as the Medicare Cost-Intensive Research Fund. The Fund would consist of such amounts as may be appropriated or credited to the Fund for research priorities identified as a result of the assessments conducted under this section.

Reason for Change

This provision will help to identify the most cost-intensive diseases and conditions in the Medicare program with the goal of informing research priorities throughout the Department of Health and Human Services to improve the quality of care the Medicare beneficiaries receive and enhance the prevention, or treatment or cure of such diseases and conditions.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

(Not Within the Jurisdiction of the Committee on Ways and Means)

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of H.R. 3200, "America's Affordable Health Choices Act."

MOTION TO REPORT RECOMMENDATIONS

The Chairman's Amendment in the Nature of a Substitute, as amended, was ordered favorably reported by a rollcall vote of 23

yeas to 18 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel	X			Mr. Camp		X	
Mr. Stark	X			Mr. Herger		X	
Mr. Levin	X			Mr. Johnson		X	
Mr. McDermott	X			Mr. Brady		X	
Mr. Lewis (GA)	X			Mr. Ryan		X	
Mr. Neal	X			Mr. Cantor		X	
Mr. Tanner		X		Mr. Linder		X	
Mr. Becerra	X			Mr. Nunes		X	
Mr. Doggett	X			Mr. Tiberi		X	
Mr. Pomeroy		X		Ms. Brown-Waite		X	
Mr. Thompson	X			Mr. Davis (KY)		X	
Mr. Larson	X			Mr. Reichert		X	
Mr. Blumenauer	X			Mr. Boustany		X	
Mr. Kind		X		Mr. Heller		X	
Mr. Pascrell	X			Mr. Roskam		X	
Ms. Berkley	X						
Mr. Van Hollen	X						
Mr. Meek	X						
Ms. Schwartz	X						
Mr. Davis (AL)	X						
Mr. Etheridge	X						
Ms. Sanchez	X						
Mr. Higgins	X						
Mr. Yarmuth	X						

VOTES ON AMENDMENTS

A rollcall vote was conducted on the following amendments to the Chairman's Amendment in the Nature of a Substitute.

A motion offered by Mr. Stark to table the motion offered by Mr. Camp to postpone proceedings was agreed to by a rollcall vote of 24 yeas to 14 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel	X			Mr. Camp		X	
Mr. Stark	X			Mr. Herger		X	
Mr. Levin	X			Mr. Johnson		X	
Mr. McDermott	X			Mr. Brady		X	
Mr. Lewis (GA)	X			Mr. Ryan		X	
Mr. Neal	X			Mr. Cantor		X	
Mr. Tanner	X			Mr. Linder		X	
Mr. Becerra	X			Mr. Nunes		X	
Mr. Doggett	X			Mr. Tiberi		X	
Mr. Pomeroy	X			Ms. Brown-Waite		X	
Mr. Thompson	X			Mr. Davis (KY)		X	
Mr. Larson	X			Mr. Reichert		X	
Mr. Blumenauer	X			Mr. Boustany		X	
Mr. Kind	X			Mr. Heller		X	
Mr. Pascrell	X			Mr. Roskam		X	
Ms. Berkley	X						
Mr. Crowley	X						
Mr. Van Hollen	X						
Mr. Meek	X						
Ms. Schwartz	X						
Mr. Davis (AL)	X						
Mr. Davis (IL)	X						
Mr. Etheridge	X						
Ms. Sanchez	X						
Mr. Higgins	X						
Mr. Yarmuth	X						

An amendment was offered by Mr. Ryan which would eliminate the public health insurance option which was defeated by a rollcall vote of 15 yeas to 25 nays. the vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz							
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Heller which would require Members of Congress and their dependents who are exchange-eligible and who enroll in health coverage to enroll in the public health insurance option which was defeated by a rollcall vote of 18 yeas to 21 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley	X						
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)	X						
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth	X						

An amendment was offered by Mr. Herger and Mr. Boustany which would prohibit CMS from making coverage determinations using comparative effectiveness research on the basis of cost was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Brady which would eliminate the public health insurance option if the Secretary of Health and Human Services determines that the public plan option's average wait time for obtaining appointments with physicians exceeds the average private insurance plan wait time was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Brady and Mr. Johnson which would strike the employer responsibility requirement was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner				Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Linder, Mr. Brady, and Mr. Heller which would prohibit the Health Insurance Exchange from operating in states that do not have malpractice rules similar to malpractice rules in the State of California was defeated by a rollcall vote of 15 yeas and 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Heller which would require that an individual's eligibility for the affordability credit requires the individual's approval under the Income and Eligibility Verification System and the Systematic Alien Verification for Entitlements programs under Section 1137 of the Social Security Act was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Mr. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Mr. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Johnson and Mr. Ryan which would prohibit abortions from being a mandated benefit in the essential benefit standard, except in the cases of rape, incest or to save the life of the mother was defeated by a rollcall vote of 18 yeas to 23 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy	X			Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Pascrell	X			Mr. Roskam	X		
Mr. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Mr. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Boustany which would prohibit the Secretary from requiring that health care providers participate in the public health insurance option was defeated by a rollcall vote of 19 yeas to 22 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy	X			Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind	X			Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Mr. Berkley	X						
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Mr. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Boustany which would prohibit the use of Federal funds in maintaining reserves for the public health insurance option and require that the public health insurance option maintain reserves consistent with the National Association of Insurance Commissioners standards was defeated by a rollcall vote of 16 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Mr. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Mr. Schwartz		X					
Mr. Davis (AL)							
Mr. Davis (IL)							
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Reichert which would allow the sale of individual insurance policies without the protections afforded by the bill which was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Camp which would delay the effective date of additional revenue offsets until the GAO certifies that the Medicare fraud rate has been reduced to below 1% of total claims and which was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz							
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Herger which would strike section 1121 of the bill (relating to Medicare physicians payment reform) and substitutes an identical provision and provides student loan forgiveness for certain primary care physicians and which was defeated by a rollcall vote of 18 yeas to 22 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy	X			Ms. Brown-Waite	X		
Mr. Thompson	X			Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz							
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Brady which would eliminate the following provisions in the subtitle containing the non-health related revenue offsets: the healthcare surcharge, delay of the implementation of the worldwide interest allocation rules, limitation on treaty benefits for certain deductible payments, codification of economic substance doctrine, and penalties for underpayments was

defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Ryan which would eliminate the Medicare solvency trigger, require the GAO to report an assessment of the impact of the Act on the Federal government's financial position, and require CBO to issue an annual report with a 75 year cost estimate on the act and which was defeated by a rollcall vote of 14 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Cantor which would prohibit funds from this bill to be used to pay for abortion or plans that cover abortion, except in the case of rape, incest, or if there exists a danger to the life of the mother was defeated by a rollcall vote of 19 yeas to 22 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy	X			Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell	X			Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)	X						
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Ms. Brown-Waite which would prohibit the Health Choices Commissioner or any other government employee from automatically enrolling any individual or family in the public health insurance option was defeated by a rollcall vote of 16 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Davis of Kentucky which would eliminate the provision that requires an employer to pay a penalty if that employer offers creditable health insurance and the employee declines that insurance and obtains coverage from the Health Insurance Exchange was defeated by a rollcall vote of 17 yeas to 24 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge	X						
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Boustany which would require CMS to seek a recommendation of the Medicare Coverage Advisory Committee with respect to certain Medicare national coverage decisions was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Roskam which would require the public health insurance option to base payment rates on fair-market rates was defeated by a rollcall vote of 19 yeas to 21 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner	X			Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy	X			Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind	X			Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge	X						
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Brady which would repeal the public health insurance option if enrollees in the option have poorer 5-year cancer survival rates than those enrolled in private health insurance offered through the Health Insurance Exchange was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)							
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Ryan which would exempt the first $200,000 ($250,000 for joint filers) in adjusted gross income from the individual responsibility payment that applies to uninsured individuals and exempt the first $250,000 of each employee's wages from the employer responsibility payment that applies to employers that do not provide health coverage was defeated by a rollcall vote of 15 yeas to 26 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

An amendment was offered by Mr. Cantor which would prohibit the Secretary of Health and Human Services from implementing rules or regulations that would restrict individuals from enrolling or purchasing a high deductible health plan that includes a health savings account, and eliminate the provision that would limit excludable reimbursements from a health savings account or an Archer Medical savings account, or under a health reimbursement or flexible spending arrangement, to prescribed drugs or insulin was defeated by a rollcall vote of 16 yeas to 25 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rangel		X		Mr. Camp	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Johnson	X		
Mr. McDermott		X		Mr. Brady	X		
Mr. Lewis (GA)		X		Mr. Ryan	X		
Mr. Neal		X		Mr. Cantor	X		
Mr. Tanner		X		Mr. Linder	X		
Mr. Becerra		X		Mr. Nunes	X		
Mr. Doggett		X		Mr. Tiberi	X		
Mr. Pomeroy		X		Ms. Brown-Waite	X		
Mr. Thompson		X		Mr. Davis (KY)	X		
Mr. Larson		X		Mr. Reichert	X		
Mr. Blumenauer		X		Mr. Boustany	X		
Mr. Kind		X		Mr. Heller	X		
Mr. Pascrell		X		Mr. Roskam	X		
Ms. Berkley	X						
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis (AL)		X					
Mr. Davis (IL)		X					
Mr. Etheridge		X					
Ms. Sanchez		X					
Mr. Higgins		X					
Mr. Yarmuth		X					

IV. BUDGET EFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 3200 as reported. The Committee anticipates that a CBO cost estimate letter will address these issues when the bill proceeds to consideration on the House floor.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

With respect to the requirements of clause 3(c)(2) of House rule XIII and section 308(a) of the Congressional Budget Act of 1974, the Committee anticipates that a CBO cost estimate letter on H.R. 3200 will address these issues when the bill proceeds to consideration on the House floor. CBO is unable to provide a cost estimate prior to the reconciliation of the versions of the bill as amended and reported by the three committees of jurisdiction.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

With respect to the requirements of 3(c)(3) of rule XIII of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee anticipates that a CBO cost estimate will address these issues when the bill proceeds to consideration on the House floor.

D. MACROECONOMIC IMPACT ANALYSIS

In compliance with clause 3(h)(2) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation provides the following macroeconomic analysis of H.R. 3200,

"America's Affordable Choices Act of 2009," as reported by the Ways and Means Committee.

Summary

The analysis examines the effects of the different parts of the bill on incentives that could affect either long-run growth or short-term fluctuations in economic activity, progressively incorporating three aspects of the bill in the analysis. All of the analysis is of expected effects within the standard Federal ten-year budget period. The first section looks at changes to the Internal Revenue Code in Title IV of the bill. Next, the effects of low income subsidies for the purchase of health insurance are added to the analysis. Finally, net changes in spending on Medicare and Medicaid are incorporated to provide a picture of the fiscal impacts of the bill as a whole. This analysis uses the Joint Committee staff's Macroeconomic Equilibrium Growth ("MEG") model to evaluate these effects.[180] The Joint Committee staff does not have a model designed to analyze possible efficiency, productivity, or labor market impacts of changes in the health sector of the economy, and thus this analysis will not include consideration of such impacts.[181]

Tax and expenditure policy can affect economic growth through several different channels. Long-term growth is determined by the availability of labor, capital and materials for the production process. In addition, in the short-run, during periods when available resources are not being fully used, growth can also be affected by changes in demand for goods and services. Changes in taxes and government spending can affect the availability of labor and capital by influencing peoples' incentives to work, save, and invest. Fiscal policy, or net changes in Federal debt, can influence long-run growth to the extent that it constrains the amount of capital available for private investment; and, it can influence short-run demand by affecting the amount of after-tax income people have to spend. In terms of the tax policy effects of the bill, H.R. 3200 contains provisions that slightly reduce incentives to work, save, and invest, resulting in a projected slight decline in GDP due to these incentives. From a fiscal policy standpoint, the bill would also result in a slight increase in Federal government debt, which may further reduce, or crowd out, the availability of funds for private investment.

Models and data

The primary focus of Joint Committee staff macroeconomic analysis is to determine the effects of changes in tax policy on the economy. In order to determine the effects of tax policy on average and marginal tax rates, the Joint Committee staff uses large microsimulation models based on large samples of individual, corporate,

[180] Descriptions of the macroeconomic equilibrium growth model and other models used by the Joint Committee staff may be found in Joint Committee on Taxation, *Overview of the Work of the Staff of the Joint Committee on Taxation to Model the Macroeconomic Effects of Proposed Tax Legislation to Comply with House Rule XIII.3(h)(2)*, JCX–105–03, December 22, 2003, and *Background Information about the Dynamic Stochastic General Equilibrium Model Used by the staff of the Joint Committee on Taxation in the Macroeconomic Analysis of Tax Policy*, JCX–52–06, December 14, 2006.

[181] For a thorough discussion of the issues and empirical evidence of the likely impacts of reforms similar to those in this bill, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December, 2008, and *Effects of Changes to the Health Insurance System on Labor Markets*, Economic and Budget Issue Brief, July 13, 2009.

and other income tax returns provided by the Statistics of Income division of the Internal Revenue Service.[182]

To analyze the effects of these tax policy changes on the economy, the current analysis relies on the Joint Committee's Macroeconomic Equilibrium Growth model.[183] The MEG model is a reduced form macroeconomic model with neoclassical foundations and myopic expectations. Peoples' willingness to work is determined by their after-tax wages and by the after-tax rate of return on additional hours of work. Changes in average and marginal tax rates affect these decisions. These labor supply decisions are modeled separately for four groups: low income primary workers, low- income secondary workers, high income primary workers, and high income secondary workers. Investment is determined by the after-tax return to capital, which is affected by changes in taxes on business and investment income. The taxation of corporate profits, proprietors' income, dividends, capital gains, and rents are each separately modeled in the MEG model.

The MEG model can be operated in an equilibrium mode, or used to simulate disequilibrium growth paths, by varying monetary policy assumptions. The equilibrium mode assumes the Federal Reserve Board omnisciently counteracts any short-term demand effects of fiscal policy to maintain the existing equilibrium. The disequilibrium growth path reflects the effects of short-term fluctuations in demand. An increase in government spending or reduction in tax rates, all else equal, would increase the amount of disposable income available to consumers, and would generally be expected to increase consumer demand. In contrast, an increase in taxes or decrease in spending or transfer payments would reduce disposable income, and thus would be likely to decrease consumer demand. Often, the Federal Reserve Board ("Fed") influences the interaction between fiscal policy and fluctuations in demand for goods and services by managing interest rates and the money supply.

The following analysis is presented using alternate assumptions about whether the Federal Reserve Board intervenes to influence the demand consequences of the policy. In the first case, the Federal Reserve Board is assumed to swiftly counteract any demand effects of the policy. In the second case, the Federal Reserve Board is assumed not to change its monetary policy at all. Generally, the Federal Reserve Board would be expected to counter the demand effects of a policy if the policy were likely to accelerate a swing in the business cycle. If the policy is counter-cyclical, or neutral, the Federal Reserve Board would be less likely to intervene. Because of current economic conditions, with the economy in a recession

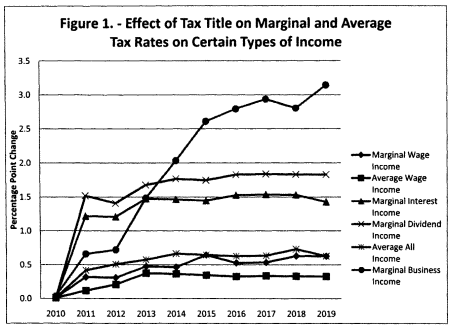
[182] These models are described in Joint Committee on Taxation, Overview of Revenue Estimating Procedures and Methodologies Used by the Staff of the Joint Committee on Taxation, JCX–1–05, February 2, 2005.

[183] To get a more complete picture of the range of possible macroeconomic effects from policy changes, it would generally be optimal to use additional models that are designed to examine the long-term growth effects of tax policy in a computable, general equilibrium framework, with either partial or perfect foresight. The Joint Committee staff has used such models in past analyses. But given the current size and projected present-law growth of deficits, the use of such models would require making very strong counterfactual assumptions about present law fiscal policy that may distort the analysis. That is, there would have to be an assumption that the Federal debt is reduced to sustainable levels in the foreseeable future in a computable general equilibrium framework. Because the policy being implemented either reduces the debt (in the case of the revenue provisions analyzed by themselves) or is close to deficit neutral (in the case of the revenue items combined with the spending provisions), in a simulation that assumed some additional provision that would reduce Federal government debt by the required amount, the effects of the debt-closing policy would overwhelm the effects of the provision being analyzed.

and the Federal Reserve Board actively engaged in providing liquidity to the economy to encourage economy expansion, it is difficult to predict how much flexibility it would have in reacting to major fiscal policy initiatives in the near future. However, since most of the provisions of H.R. 3200 would not take effect until 2013, this consideration should be of less relevance than it would be in the current year.

Analysis

Effects of the revenue provisions.—Title IV of H.R. 3200 includes several provisions to provide incentives to increase health insurance coverage, and several provisions to raise revenues to finance the increases in health insurance coverage. The coverage-related revenue provisions include taxes on certain individuals who fail to obtain coverage, and taxes on employers who fail to offer health insurance to their employees or who offer insurance that is not deemed "affordable" and whose employees obtain subsidized coverage through the new health insurance exchange. The following analysis first examines the macroeconomic effects of these revenue provisions. The provisions are projected to result in a net increase in Federal revenues of approximately $790 billion between 2010 and 2019. Figure 1 illustrates the effects of these provisions on aggregate average and marginal tax rates on various sources of income. While the average and marginal tax rates of four different labor groups are separately modeled, for ease of exposition, Figure 1 shows combined wage tax effects. These rates are calculated including some of the behavioral responses to tax changes (such as timing, portfolio effects, and other shifting of income to minimize taxation) that are included in conventional Joint Committee staff revenue estimates.



The most significant of the revenue provisions in this bill is the imposition of a surcharge on adjusted gross incomes ("AGI") above $350,000 for joint filers and $280,000 for single filers, and heads of households. The surcharge is graduated. In 2011, the surtax begins at a rate of one percent on amounts up to $500,000 for joint filers, and $400,000 for individual filers, and increases to 5.4 percent on amounts above $1 million and $800,000 respectively. In 2013, the surtax rates range from two percent to 5.4 percent. Average and marginal tax rates on wages of high income earners are increased by roughly equivalent amounts due to this provision. The increase in average tax rates reduces disposable income, providing some incentive to increase labor supply, while the increase in mar-

ginal tax rates on wages reduces the after-tax earnings of additional labor; on net the tax changes provide an incentive for affected taxpayers to reduce their labor supply. Because the surtax applies to all income above the AGI threshold, it also taxes income generated from business activities of sole proprietors, partners, S-Corporation shareholders, and other individuals receiving income from capital. The increased tax on business income reduces the return to business activities, thus reducing incentives to invest in business activities.

Additional provisions affecting individual taxpayers include a penalty on individuals with income above the income tax filing threshold who fail to purchase health insurance, a provision to conform the definition of qualified medical expenditures for Flexible Spending Arrangements, Individual Health Arrangements, Health Savings Accounts, and Medical Savings Accounts to the definition provided under Code section 223, and a provision to provide for certain health benefits currently applicable to a taxpayer's spouse and dependents to certain other beneficiaries. The net effect of these provisions is to slightly increase average and marginal tax rates on individual income.

Additional business-related provisions that are part of health reform include employer responsibility payments assessed on employers with payrolls above $250,000 in 2013 that fail to provide health insurance for their employees, and tax credits for up to 50 percent of the cost of employee health insurance by businesses with fewer than 26 employees and average wages less than $40,000. Additional business tax provisions that contribute to raising revenues include delaying the implementation of worldwide interest allocation for multinational firms until 2020, limiting eligibility for reduced withholding under certain treaties, and codification of the economic substance doctrine for assessing whether certain transactions should generate tax liabilities. The net effect of these additional business tax provisions is to slightly increase average and marginal tax rates on businesses with more than 25 employees.

Table 1 shows the effects of the revenue provisions contained in Title W of H.R. 3200 on economic growth, measured as percent changes in Gross Domestic Product ("GDP") relative to present-law baseline projections, and other key macroeconomic aggregates.

TABLE 1.—EFFECTS OF REVENUE PROVISIONS PERCENT CHANGE RELATIVE TO PROJECTED PRESENT LAW LEVELS

	Fed Counters Demand Response [Percent]		No Fed Reaction [Percent]	
	2010–14	2015–19	2010–14	2015–19
Nominal GDP	−0.1	−0.4	−0.4	−1.5
Real GDP	−0.1	−0.2	−0.2	−0.3
Real producers' capital stock	−0.2	−0.6	−0.2	−0.7
Labor force participation	−0.1	−0.1	−0.1	−0.1
Employment	−0.1	−0.2	−0.2	−0.3
Real consumption	−0.3	−0.5	−0.4	−0.7
Change in long-term interest rates (basis points)	−3	−32	−5	−39
Receipts feedback (percent change in receipts due to change in GDP)	−0.1	−0.4	−0.2	−0.6

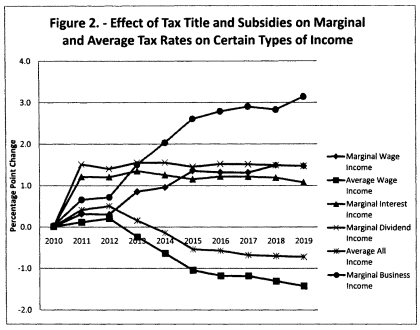
Consistent with the negative incentives for both labor supply and business investment described above, relative to present law, labor force participation is projected to fall by about 0.1 percent relative to the baseline, and business capital stock is projected to fall by 0.2 percent in the early years, and by up to 0.7 percent in the longer run. Because the policy reduces disposable income, it also exerts a downward pressure on demand. Nominal GDP is projected to fall by 0.1 to 0.4 percent in the 2010–2014 and by 0.4 percent to 1.5 percent in 2015–2019, depending on whether the Federal Reserve Board counteracts the downward pressure on demand. Real (inflation-adjusted) GDP would decline by 0.1 to 0.4 percent in 2010–14 and 0.2 to 0.3 percent in 2015–19. Consumption is also projected to fall relative to the baseline by 0.3 to 0.4 percent in 2010–14 and 0.5 to 0.7 percent in 2015–19. One positive effect of these provisions on the economy is a decline in long-term interest rates by up to 39 basis points in the long run due to the reduction in Federal debt. Because of the decline in GDP relative to the baseline, the taxable income base is reduced, and receipts would be 0.1 percent to 0.6 percent lower taking growth effects into account.

Effects of revenue provisions and health insurance subsidies combined.—Beginning in 2013, Title II of H.R. 3200 also provides for subsidies for the purchase of certain qualified health insurance through new health insurance exchanges. These subsidies, referred to as "affordability credits," along with out-of-pocket cost sharing assistance are available to individuals and families with adjusted gross incomes below 400 percent of the Federal poverty level. The affordability credits and subsidies, cost approximately $840 billion from 2010–2019. On net, the subsidies and tax provisions together increase Federal government debt by approximately $50 billion from 2010–2019.

Because of the way the affordability credits are structured, they have incentive effects similar to those of refundable tax credits. The subsidies themselves increase disposable income, just as reductions in average tax rates would for eligible individuals, reducing incentives to work. Because the credits are phased out by income levels, they have the same incentive effect with respect to income-producing activities as increasing marginal tax rates for eligible individuals reducing the return to additional income generation, and thus reducing incentives to work and invest. The affordability credits are designed to assist low-income individuals in purchasing qualified health insurance in compliance with a requirement that everyone have health insurance coverage. The increased health coverage could lead to increased consumption of medical services, which could in turn lead both to changes in individual health status and productivity. In addition, changes in demand for health care services within the context of the health market reforms included in the bill could produce significant changes in the health service delivery system, which could impact the efficiency of the health sector and/or the productivity of the population. The availability of subsidized, risk-pooled health insurance outside of the employment context could also affect people's decisions regarding job changes and retirement. Such effects are beyond the scope of this analysis.

Figure 2 shows the combined effects of the revenue provisions of Title IV and the subsidy provisions of Title II of H.R. 3200. Overall,

the effective marginal rate on aggregate wage income continues to increase, while the aggregate average rate declines. In particular, effective marginal tax rates increase for individuals qualifying for the subsidy (whose income is below 400 percent of the Federal poverty level), and for those subject to the surtax (whose adjusted gross income is above $350,000). While the average rate for those subject to the surtax increases, effective average rates (accounting for the subsidy) for subsidy-eligible individuals decrease by a greater amount.



Similarly, Table 2 shows the combined macroeconomic effects of these two Titles of H.R. 3200. Relative to the present law baseline, real GDP is projected to decrease by slightly more from 2015–19, 0.4 percent under the combined tax and subsidy proposal than the with the revenue provisions alone. The combination of tax increases and affordability credits is projected to reduce labor force participation by 0.3 percent between 2015–2019, more than the effects of the revenue provisions alone. Employment is also projected to be reduced relative to what it would be under present law. Because Federal debt is only slightly increased under this scenario, there is little change in long-term interest rates; thus more private investment is displaced by public debt in this scenario relative to the tax provisions alone, and producers' capital stock falls by 0.2 percent in 2010–14 and 1.3 percent in 2015–2019. Conversely, because disposable income is not being contracted, there is little short-run demand effect, with little difference between the effects of the proposal on nominal versus real GDP. The decline in GDP and associated macroeconomic aggregates relative to the present law baseline would result in receipts decreasing by 0.1 to 0.5 percent.

TABLE 2.—EFFECTS OF TAX PROVISIONS AND EXCHANGE SUBSIDIES PERCENT CHANGE RELATIVE TO PROJECTED PRESENT LAW LEVELS

	Fed Counters Demand Response [Percent]		No Fed Reaction [Percent]	
	2010–14	2015–19	2010–14	2015–19
Nominal GDP	−0.1	−0.4	−0.3	−0.3
Real GDP	−0.1	−0.4	−0.2	−0.2
Real producers' capital stock	−0.2	−1.3	−0.2	−1.2
Labor force participation	−0.1	−0.3	−0.1	−0.3
Employment	−0.1	−0.3	−0.2	−0.1
Real consumption	−0.2	−0.3	−0.2	−0.3

TABLE 2.—EFFECTS OF TAX PROVISIONS AND EXCHANGE SUBSIDIES PERCENT CHANGE RELATIVE TO PROJECTED PRESENT LAW LEVELS—Continued

	Fed Counters Demand Response [Percent]		No Fed Reaction [Percent]	
	2010–14	2015–19	2010–14	2015–19
Change in long-term interest rates (basis points)	−1	−3	−5	−2
Receipts feedback (percent change in receipts due to change in GDP)	−0.1	−0.5	−0.2	−0.4

Fiscal effects of the entire bill.—Finally, H.R. 3200 makes many changes to the Medicare and Medicaid programs. The net effect of these changes, in combination with the revenue provisions and the exchange subsidies, is to increase the Federal deficit by approximately $220 billion from 2010–2019. The Joint Committee staff models the Medicaid and Medicare changes as changes in untaxed transfer payments received by taxpayers. As with the affordability subsidies for the purchase of health insurance, these program changes could have effects on the health care delivery system, but these effects are not incorporated in this analysis.

Because any income phase-outs associated with the changes to Medicare and Medicaid have not been modeled, the changes in effective marginal tax rates and average tax rates in this scenario are the same as in the second scenario, shown in Figure 2 above. Only the net effects of these changes on personal disposable income and Federal government debt are considered in this analysis. Table 3 shows the growth effects of the combined revenue provisions, affordability subsidies, and changes to Medicare and Medicaid.

TABLE 3.—EFFECTS OF TAX PROVISIONS, SUBSIDIES, AND CHANGES IN OTHER OUTLAYS PERCENT CHANGE RELATIVE TO PROJECTED PRESENT LAW LEVELS

	Fed Counters Demand Response [Percent]		No Fed Reaction [Percent]	
	2010–14	2015–19	2010–14	2015–19
Nominal GDP	−0.1	−0.4	−0.2	0.1
Real GDP	−0.1	−0.4	−0.1	−0.1
Real producers' capital stock	−0.2	−1.5	−0.2	−1.4
Labor force participation	−0.1	−0.3	−0.1	−0.3
Employment	−0.1	−0.3	−0.1	0.0
Real consumption	−0.2	−0.2	−0.3	0.0
Change in long-term interest rates (basis points)	1	8	−1	11
Receipts feedback (percent change in receipts due to change in GDP)	−0.1	−0.6	−0.2	−0.3

Because effective tax rates are the same in this scenario as in the one above, incentives for work remain the same, and labor force participation is again projected to decline relative to the present law baseline by 0.1 percent from 2010–14 and by 0.3 percent in 2015–19. One noticeable difference between this scenario and the others is the increase in long-term interest rates that results from the increase in Federal government debt. The increased debt crowds out more private investment, reducing business capital stock by up to 1.5 percent in 2015–19. The increase in disposable income also leads to more short-term demand pressure, resulting in smaller declines from the baseline in GDP in the case where the

Fed does not attempt to counteract the demand effect. Changes in GDP continue to reduce Federal receipts by modest amounts, by 0.1 to 0.2 percent in 2010–14 and 0.3 to 0.6 percent in 2015–19.

Conclusion.—The revenue, subsidy, and overall fiscal effects of H.R. 3200 create moderately negative growth incentives through raising marginal tax rates on labor and capital and through the interest-rate increase owing to increased deficits. When the revenue provisions are considered alone, the negative incentive effects are somewhat offset by the reduction in long run interest rates.

E. PAY-GO RULE

In compliance with clause 10 of rule XXI of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 3200 as reported: the Committee anticipates that a CBO cost estimate letter on H.R. 3200 will address these issues when the bill proceeds to consideration on the House floor. CBO is unable to provide a cost estimate prior to the reconciliation of the versions of the bill as amended and reported by the three committees of jurisdiction.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was a result of the Committee's oversight review concerning the tax burden on taxpayers that the Committee concluded that it is appropriate and timely to enact the revenue provision included in the bill as reported.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the goal of H.R. 3200, America's Affordable Health Choices Act of 2009 is to provide affordable, quality health care for all Americans and reduce the rate of growth in health care spending.

C. CONSTITUTIONAL AUTHORITY STATEMENT

With respect to clause 3(d)(1) of the rule XIII of the Rules of the House of Representatives (relating to Constitutional Authority), the Committee states that the Committee's action in reporting this bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises. . . "), and from the 16th Amendment to the Constitution.

D. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the bill contains nine private sector mandates: (i) Tax on individual without acceptable health care coverage; (ii) Election to satisfy health coverage partici-

pation requirements; (iii) Responsibilities of nonelecting employers; (iv) Comparative effectiveness research trust fund; financing for trust fund; (v) Impose a surcharge for certain AGI; (vi) Modify the definition of qualified medical expenses for purposes of HRAs, health FSAs, HSAs, and Archer MSAs; (vii) Delay implementation of worldwide interest allocation until 2020; (viii) Limit eligibility for reduced treaty withholding rates based on residency of foreign parent; and (ix) Codification of economic substance doctrine and penalties for underpayments.

The Committee has determined that the bill contains one intergovernmental mandate on State, local, or tribal governments: Responsibilities of nonelecting employers.

E. APPLICABILITY OF HOUSE RULE XXI 5(B)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not involve any Federal income tax rate increases within the meaning of the rule.

F. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation a summary description of the provision is provided along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding each of the provisions included in the complexity analysis.

1. Tax on individuals without acceptable health care coverage

Summary description of the provision

The provision taxes individuals who do not maintain coverage under acceptable health insurance for themselves and their qualifying children. The tax is equal to the lesser of (a) the national average premium for single or family coverage, as applicable, or (b) 2.5 percent of the excess of the taxpayer's adjusted gross income ("AGI") over the threshold filing amount. Acceptable coverage includes a health plan that covers at least an essential benefits package and that includes certain specified limits on required cost shar-

ing, no annual or lifetime limit on covered health care items or services, certain specified minimum services, and certain requirements as to network adequacy as determined by the newly appointed Health Choices Commissioner. Acceptable coverage also includes a grandfathered plan, Medicare, Medicaid, Tricare (and other Armed Services coverage), Veterans Administration coverage, and certain other coverage. Those exempt from the penalty include: nonresident aliens, U.S. citizens and residents living abroad, those who can claim health insurance would cause financial hardship, those whose income is below the threshold for filing a Federal income tax return, and those who are properly claimed as dependents on the income tax return of another taxpayer for the taxable year. Individuals maintaining health insurance for part of the year are required to pay a pro-rated tax.

The new additional tax for failure to maintain health insurance is accompanied by new reporting requirements for insurance providers. Any insurance provider is required to provide information to the Department of Treasury and the primary insured individual. The return is required to supply the name, address, and taxpayer identification numbers of all individuals receiving. insurance under the policy by January 31 of the year following the calendar year the insurance was provided. Failure to file the required information return or to include complete and correct information on the required return is subject to the failure to file correct information returns penalty of section 6721.

Number of affected taxpayers

It is estimated that the provision will affect more than 10 percent of individual or small business tax returns.

Discussion

The provision creates a reporting requirement for providers of insurance coverage. The reporting requirement obliges the provision of the following information to both the insured individual and the Department of Treasury directly: the name of all insured on the policy, the dates of insurance coverage during the tax year, the Taxpayer Identification Numbers ("TINs") and any other information required by the Secretary. In addition, the insurer will have the added responsibility of determining which insurance plan offerings meet the standard of "qualified coverage."

For individuals for whom there is no additional tax, while the statute creates no requirement for the filing of insurance information by the taxpayer, the taxpayer will receive this information and discretion is left to the Secretary of Treasury for prescribing regulations to carry out the statute, which could include a supplemental reporting requirement from the individual. The 1040, 1040A and 1040–EZ must be amended to add a new line to reflect any additional tax. Individuals owing additional tax will be required to include the amount of the tax owed both on a new form and on the 1040, 1040A or 1040–EZ.

The Internal Revenue Service ("IRS") will be required to reprogram computers to reflect the additional rules, forms and information from employers, insurers and individuals. In addition, regulations would be needed to reflect statutory exemptions from the additional tax and resources needed to resolve disputes regarding

maintenance of acceptable coverage and eligibility for exemption from additional tax.

2. Election to satisfy health coverage participation requirements and responsibilities of nonelecting employers

Summary description of the provision

The provisions create a system under which employers must elect whether to offer health benefits to employees. For employers that elect not to offer health benefits to their employees, the provisions establish a payroll tax equal to eight percent of the wages paid to employees.

Employers that elect to offer health benefits are not required to pay the payroll tax. However, employers that elect to offer health benefits but fail to comply with the rules governing offers of coverage are subject to an excise tax. In addition, beginning in the second year after enactment of the provisions, employers that elect to offer health benefits are required to make contributions, in the amount of eight percent of the average wages paid to employees, to the Health Insurance Exchange for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. Finally, employers that elect to offer health benefits to their employees must file an additional return with the IRS containing information about the insured, the period for which coverage was provided, and such other information as the Secretary of the Treasury may require. Similar returns must be filed with the insured employees as well.

Special rules apply for certain small businesses. An employer with an annual payroll that does not exceed $250,000 is exempt from the requirement to offer health benefits or pay a payroll tax and the requirement to make contributions to the Health Insurance Exchange for employees who decline employer-provided coverage in the event that such coverage is offered. For an employer with an annual payroll from $250,000 through $400,000, the eight-percent payroll tax applicable to nonelecting employers, or the eight-percent of wages contribution to the Health Exchange Fund for coverage-declining employees, phases in ratably.

Number of affected taxpayers

It is estimated that the provision will affect more than 10 percent of small business tax returns.

Discussion

It is anticipated that small businesses will have to keep additional records and perform additional analysis to comply with the new election and coverage requirements. Small businesses will need to make an affirmative election regarding whether to be subject to the national health coverage participation requirements. Small businesses that elect to offer health benefits will be required to set up provisions for auto-enrolling their employees in one of the employer-offered health plans, and must develop and disseminate written notices informing employees of their rights and obligations relating to the automatic enrollment, including the ability to opt-out of enrollment in the employer-provided plan. Small businesses that elect to provide health coverage to their employees will be re-

quired to file an additional return with the IRS containing information about the insured, the period for which coverage was provided, and such other information as the Secretary of the Treasury may require. Similar returns must be filed with the insured employees as well. Small businesses will have to maintain records documenting their election, which employees were provided coverage, whether appropriate taxes for non-covered employees were paid, and that the business filed all necessary reports with the IRS.

It is anticipated that the IRS will have to develop new forms to capture the election by employers whether to provide qualifying health care coverage. The IRS will also have to amend existing forms to implement the provision imposing a tax on employers who fail to satisfy the health coverage participation requirement, and revise several publications to explain the election, participation requirements, and tax imposed by the provisions.

It is anticipated that the IRS will be required to make numerous computer programming changes to tax systems that support employment and excise tax forms required to be filed by employers. The computer systems will also need to be changed to accommodate the new payroll tax and excise taxes requirements. Computer programming changes will be required to accommodate the new information return that will be filed with the IRS by employers.

The Department of the Treasury will have to issue regulations or other guidance regarding employers' elections, the application of the new tax, and the exceptions for failure to comply with the applicable coverage rules and the new reporting requirements (including details as to content and how to report).

The Secretary of the Treasury will be required to coordinate enforcement of the provision with the Secretaries of Labor and Health and Human Services and the Health Choices Commissioner to ensure uniform interpretation and enforcement of the provision. The four agencies will be required to execute an interagency memorandum of understanding.

3. Distribution for medicine qualified only if for prescribed drug or insulin

Summary description of the provision

Under the provision, the cost of over-the-counter medicines may not be reimbursed with excludible income through health flexible spending arrangements under a cafeteria plan ("Health FSAs"), health reimbursement arrangements ("HRAs"), Health Savings Accounts ("HSAs"), or Archer MSAs.

Number of affected taxpayers

It is estimated that the provision will affect more than 10 percent of individual tax returns.

Discussion

Many taxpayers currently use account balances in Health FSAs, HRAs, HSAs, and Archer MSAs to purchase over-the-counter medicine such as ibuprofen, acetaminophen, cold medicine, and suntan lotion with pre-tax dollars. Some taxpayers make these purchases at the end of the year, or the end of the grace period, to avoid forfeiting amounts in Health FSAs. Taxpayers will no longer be able

to use these amounts in these accounts for this purpose. As a result, less money will be allocated to these accounts and more money will be allocated to taxable wages. This change will also increase the amount of compensation subject to payroll taxes.

It is anticipated that the IRS will be required to revise the instructions to several forms and to revise several publications to reflect the changes to present law made by the provision. In addition, guidance will need to be issued withdrawing at least one Revenue Ruling and guidance may need to be issued on substantiation rules for reimbursement arrangements.

G. LIMITED TAX BENEFITS

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, the Ways and Means Committee has determined that the bill as reported contains no congressional earmarks, limited tax benefits or limited tariff benefits within the meaning of that rule.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rule of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

SEC. 226A. (a) * * *

(b) Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of title XVIII by reasons of this section on the basis of end stage renal disease—

(1) * * *

(2) shall end, in the case of an individual who receives a kidney transplant *(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))*, with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

* * * * * * *

[(c)**]** *(d)* For purposes of this section, each person whose monthly insurance benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 225(c) shall be treated as entitled to such benefit for such month.

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TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

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PART B—CHILD AND FAMILY SERVICES

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Subpart 3—Support for Quality Home Visitation Programs

SEC. 440. HOME VISITATION PROGRAMS FOR FAMILIES WITH YOUNG CHILDREN AND FAMILIES EXPECTING CHILDREN.

(a) PURPOSE.—The purpose of this section is to improve the well-being, health, and development of children by enabling the establishment and expansion of high quality programs providing voluntary home visitation for families with young children and families expecting children.

(b) GRANT APPLICATION.—A State that desires to receive a grant under this section shall submit to the Secretary for approval, at such time and in such manner as the Secretary may require, an application for the grant that includes the following:

(1) DESCRIPTION OF HOME VISITATION PROGRAMS.—A description of the high quality programs of home visitation for families with young children and families expecting children that will be supported by a grant made to the State under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children in the State;

(B) the number and types of families who are receiving services under the programs;

(C) the sources and amount of funding provided to the programs;

(D) the gaps in home visitation in the State, including identification of communities that are in high need of the services; and

(E) training and technical assistance activities designed to achieve or support the goals of the programs.

(3) ASSURANCES.—Assurances from the State that—

(A) in supporting home visitation programs using funds provided under this section, the State shall identify and prioritize serving communities that are in high need of such services, especially communities with a high proportion of low-income families or a high incidence of child maltreatment;

(B) the State will reserve 5 percent of the grant funds for training and technical assistance to the home visitation programs using such funds;

(C) in supporting home visitation programs using funds provided under this section, the State will promote coordi-

nation and collaboration with other home visitation programs (including programs funded under title XIX) and with other child and family services, health services, income supports, and other related assistance;

(D) home visitation programs supported using such funds will, when appropriate, provide referrals to other programs serving children and families; and

(E) the State will comply with subsection (i), and cooperate with any evaluation conducted under subsection (j).

(4) OTHER INFORMATION.—Such other information as the Secretary may require.

(c) ALLOTMENTS.—

(1) INDIAN TRIBES.—From the amount reserved under subsection (l)(2) for a fiscal year, the Secretary shall allot to each Indian tribe that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the amount so reserved as the number of children in the Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (l), the Secretary shall allot to each State that is not an Indian tribe and that meets the requirement of subsection (d), if applicable, for the fiscal year the amount that bears the same ratio to the remainder of the amount so appropriated as the number of children in the State whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such States whose families have income that does not exceed 200 percent of the poverty line.

(3) REALLOTMENTS.—The amount of any allotment to a State under a paragraph of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section shall be available for reallotment using the allotment methodology specified in that paragraph. Any amount so reallotted to a State is deemed part of the allotment of the State under this subsection.

(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection for a fiscal year if the Secretary finds that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

(e) PAYMENT OF GRANT.—

(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d), if applicable, for a fiscal year for which funds are appropriated under subsection (m), in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term "reimbursable percentage" means, with respect to a fiscal year—

(A) 85 percent, in the case of fiscal year 2010;

(B) 80 percent, in the case of fiscal year 2011; or

(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year.

(f) ELIGIBLE EXPENDITURES.—

(1) IN GENERAL.—In this section, the term "eligible expenditures"—

(A) means expenditures to provide voluntary home visitation for as many families with young children (under the age of school entry) and families expecting children as practicable, through the implementation or expansion of high quality home visitation programs that—

(i) adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes, such as reducing abuse and neglect and improving child health and development;

(ii) employ well-trained and competent staff, maintain high quality supervision, provide for ongoing training and professional development, and show strong organizational capacity to implement such a program;

(iii) establish appropriate linkages and referrals to other community resources and supports;

(iv) monitor fidelity of program implementation to ensure that services are delivered according to the specified model; and

(v) provide parents with—

(I) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains (including knowledge of second language acquisition, in the case of English language learners);

(II) knowledge of realistic expectations of age-appropriate child behaviors;

(III) knowledge of health and wellness issues for children and parents;

(IV) modeling, consulting, and coaching on parenting practices;

(V) skills to interact with their child to enhance age-appropriate development;

(VI) skills to recognize and seek help for issues related to health, developmental delays, and social, emotional, and behavioral skills; and

(VII) activities designed to help parents become full partners in the education of their children;

(B) includes expenditures for training, technical assistance, and evaluations related to the programs; and

(C) does not include any expenditure with respect to which a State has submitted a claim for payment under any other provision of Federal law.

(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEST EVIDENCE.—

(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of programs that do not adhere to a model of home visitation with the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year to the extent that the total of the expenditures exceeds the applicable percentage for the fiscal year of the allotment of the State under subsection (c) for the fiscal year.

(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term "applicable percentage" means, with respect to a fiscal year—

(i) 60 percent for fiscal year 2010;

(ii) 55 percent for fiscal year 2011;

(iii) 50 percent for fiscal year 2012;

(iv) 45 percent for fiscal year 2013; or

(v) 40 percent for fiscal year 2014.

(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the failure to do so would impose an undue burden on the Indian tribe.

(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

(A) the Secretary waives the requirement; or

(B) the Secretary modifies the requirement, and the Indian tribe meets the modified requirement.

(i) STATE REPORTS.—Each State to which a grant is made under this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

(1) the services delivered by the programs that received funds from the grant;

(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

(5) the annual cost of implementing the program, including the cost per family served under the program;

(6) the outcomes experienced by recipients of services through the program;

(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

(8) the indicators and methods used to monitor whether the program is being implemented as designed; and

(9) other information as determined necessary by the Secretary.

(j) EVALUATION.—

(1) IN GENERAL.—The Secretary shall, by grant or contract, provide for the conduct of an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

(2) REPORTS TO THE CONGRESS.—

(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to the Congress an interim report on the evaluation conducted pursuant to paragraph (1).

(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to the Congress a final report on the evaluation conducted pursuant to paragraph (1).

(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to the Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

(1) The high need communities targeted by States for programs carried out under this section.

(2) The service delivery models used in the programs receiving funds provided under this section.

(3) The characteristics of the programs, including—

(A) the qualifications and demographic characteristics of program staff; and

(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

(4) The outcomes reported by the programs.

(5) The research-based instruction, materials, and activities being used in the activities funded under the grant.

(6) The training and technical activities, including on-going professional development, provided to the programs.

(7) The annual costs of implementing the programs, including the cost per family served under the programs.

(8) The indicators and methods used by States to monitor whether the programs are being been implemented as designed.

(l) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (m), the Secretary shall reserve—

(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (j), and the provision to States of training and technical assistance, including the dissemination of best practices in early childhood home visitation; and

(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

(1) $50,000,000 for fiscal year 2010;

(2) $100,000,000 for fiscal year 2011;

(3) $150,000,000 for fiscal year 2012;

(4) $200,000,000 for fiscal year 2013; and

(5) $250,000,000 for fiscal year 2014.

(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 431(a) shall apply.

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

* * * * * * *

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a) * * *

* * * * * * *

(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

(1) DISCLOSURE.—A facility (as defined in paragraph (7)(B)) shall have the information described in paragraph (3) available—

(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 1411(b) of the America's Affordable Health Choices Act of 2009, for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

(B) beginning on the effective date of the final regulations promulgated under paragraph (4)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

(2) PUBLIC AVAILABILITY OF INFORMATION.—During the period described in paragraph (1)(A), a facility shall—

(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information; and

(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

(3) INFORMATION DESCRIBED.—

(A) IN GENERAL.—The following information is described in this paragraph:

(i) The information described in subsections (a) and (b), subject to subparagraph (C).

(ii) The identity of and information on—

(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

(III) each person or entity who is an additional disclosable party of the facility.

(iii) The organizational structure of each person and entity described in subclauses (II) and (III) of clause (ii) and a description of the relationship of each such person or entity to the facility and to one another.

(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such Form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

(i) with respect to subsections (a) and (b), "ownership or control interest" shall include direct or indirect interests, including such interests in intermediate entities; and

(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

(4) REPORTING.—

(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (3) to the

Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is accurate and current.

(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

(5) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

(6) DEFINITIONS.—In this subsection:

(A) ADDITIONAL DISCLOSABLE PARTY.—The term "additional disclosable party" means, with respect to a facility, any person or entity who—

(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property;

(iii) lends funds or provides a financial guarantee to the facility in an amount which is equal to or exceeds $50,000; or

(iv) provides management or administrative services, clinical consulting services, or accounting or financial services to the facility.

(B) FACILITY.—The term "facility" means a disclosing entity which is—

(i) a skilled nursing facility (as defined in section 1819(a)); or

(ii) a nursing facility (as defined in section 1919(a)).

(C) MANAGING EMPLOYEE.—The term "managing employee" means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

(D) ORGANIZATIONAL STRUCTURE.—The term "organizational structure" means, in the case of—

(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

(iii) a general partnership, the partners of the general partnership;

(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

(v) a trust, the trustees of the trust;

(vi) an individual, contact information for the individual; and

(vii) any other person or entity, such information as the Secretary determines appropriate.

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) * * *

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

(1) * * *

(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION *OR AUDIT*.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any [investigation into any criminal offense described in paragraph (1) or in subsection (a).] *investigation or audit related to—*

(i) any offense described in paragraph (1) or in subsection (a); or

(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).

* * * * * * *

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing*, ordering, referring for furnishing, or certifying the need for* items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

* * * * * * *

(c) NOTICE, EFFECTIVE DATE, [AND PERIOD] *PERIOD, AND EFFECT* OF EXCLUSION.—(1) * * *

* * * * * * *

(3)(A) * * *

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on [individuals entitled to benefits under part A of title XVIII

or enrolled under part B of such title, or both] *beneficiaries (as defined in section 1128A(i)(5)) of that program*, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

* * * * * * *

(4)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no payment may be made by any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

(i) by an excluded individual or entity; or

(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person submitting a claim for such item or service knew or had reason to know of the exclusion of such individual.

(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly provided, ordered, manufactured, distributed, prescribed, or otherwise supplied the item or service regardless of how the item or service was paid for by a Federal health care program or to whom such payment was made.

(C)(i) Payment may be made under a Federal health care program for emergency items or services (not including items or services furnished in an emergency room of a hospital) furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of such individual's exclusion.

(ii) In the case that an individual eligible for benefits under title XVIII or XIX submits a claim for payment for items or services furnished by an excluded individual or entity, and such individual eligible for such benefits did not know or have reason to know that such excluded individual or entity was so excluded, then, notwithstanding such exclusion, payment shall be made for such items or services. In such case the Secretary shall notify such individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to an individual eligible for such benefits after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the individual eligible for such benefits of the exclusion of the individual or entity furnishing the items or services.

(iii) In the case that a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than an individual eligible for benefits under title XVIII or XIX or the excluded individual or entity, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant Federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to

the individual or entity that submitted the claim for the items or services furnished by the excluded individual or entity. If a Federal health care program contractor provided inaccurate or misleading information that resulted in the waiver of an overpayment under this clause, the Secretary shall take appropriate action to recover the improperly paid amount from the contractor.

* * * * * * *

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) * * *

* * * * * * *

(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented [to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1))], a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) * * *

* * * * * * *

(D) is for a medical or other item or service furnished during a period in which the person was excluded [from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or] *under Federal law from the Federal health care program under which the claim was made, or*

* * * * * * *

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from [participating in a program under title XVIII or a State health care program] *participating in a Federal health care program (as defined in section 1128B(f))* in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under [title XVIII or a State health care program] *a Federal health care program (as defined in section 1128B(f))*, and

who knows or should know of the action constituting the basis for the exclusion; or

* * * * * * *

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program; [or]

(7) commits an act described in paragraph (1) or (2) of section 1128B(b);

(8) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

(9) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;

(10) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

(11) orders or prescribes an item or service, including without limitation home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, or any other item or service, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;

(12) conspires to commit a violation of this section; or

(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; [or in cases under paragraph (7), $50,000 for each such act)] *in cases under paragraph (7), $50,000 for each such act,* [or in cases under paragraph (8)] *in cases under paragraph (8)*, $50,000 for each false statement, omis-

sion, or misrepresentation of a [material fact)] *a material fact, in cases under paragraph (9), $50,000 for each false record or statement, or in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph, in cases under paragraph (11), $50,000 for each order or prescription for an item or service by an excluded individual, in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decrease)*. In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received [for a lawful purpose)] *for a lawful purpose, in cases under paragraph (8), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased)*. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

* * * * * * *

(c)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than [six years] *10 years* after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

* * * * * * *

(i) For the purposes of this section:

(1) * * *

[(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1128B(f)).

[(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for pay-

ment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.]

(2) The term "claim" means any application, request, or demand, whether under contract, or otherwise, for money or property for items and services under a Federal health care program (as defined in section 1128B(f)), whether or not the United States or a State agency has title to the money or property, that—

(A) is presented or caused to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)); or

(B) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the Federal health care program's behalf or to advance a Federal health care program interest, and if the Federal health care program—

(i) provides or has provided any portion of the money or property requested or demanded; or

(ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(3) The term "item or service" means, without limitation, any medical, social, management, administrative, or other item or service used in connection with or directly or indirectly related to a Federal health care program.

* * * * * * *

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include—

(A) * * *

* * * * * * *

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996; [or]

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated[.]*; or*

[(D)] *(E)* a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).

[(7) The term "should know" means that a person, with respect to information—

[(A) acts in deliberate ignorance of the truth or falsity of the information; or

[(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.]

(7) The terms "knowing", "knowingly", and "should know" mean that a person, with respect to information—

(A) has actual knowledge of the information;

(B) acts in deliberate ignorance of the truth or falsity of the information; or

(C) acts in reckless disregard of the truth or falsity of the information;

and require no proof of specific intent to defraud.

(8) The term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

(9) The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

* * * * * * *

FRAUD AND ABUSE CONTROL PROGRAM

SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) * * *

* * * * * * *

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse, *and*

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D[, and].

[(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.]

* * * * * * *

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. (a) GENERAL PURPOSE.—[Not later than] *Subject to subsection (h), not later than* January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c), and shall maintain a database of the information collected under this section.

* * * * * * *

(d) ACCESS TO REPORTED INFORMATION.—

(1) * * *

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database [(other than with respect to requests by Federal agencies)]. The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

* * * * * * *

(h) SUNSET OF THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK; TRANSITION PROCESS.—Effective upon the enactment of this subsection, the Secretary shall implement a process to eliminate duplication between the Healthcare Integrity and Protection Data Bank (in this subsection referred to as the "HIPDB" established pursuant to subsection (a) and the National Practitioner Data Bank (in this subsection referred to as the "NPDB") as implemented under the Health Care Quality Improvement Act of 1986 and section 1921 of this Act, including systems testing necessary to ensure that information formerly collected in the HIPDB will be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Except as otherwise provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report), access to, and other treatment of the information specified in this section.

* * * * * * *

SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PROTECTIONS IN THE MEDICARE, MEDICAID, AND CHIP PROGRAMS.

(a) CERTAIN AUTHORIZED SCREENING, ENHANCED OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—

(1) IN GENERAL.—For periods beginning after January 1, 2011, in the case that the Secretary determines there is a significant risk of fraudulent activity (as determined by the Secretary based on relevant complaints, reports, referrals by law enforcement or other sources, data analysis, trending information, or claims submissions by providers of services and suppliers) with respect to a category of provider of services or supplier of items or services, including a category within a geographic area, under title XVIII, XIX, or XXI, the Secretary may impose any of the following requirements with respect to a provider of services or a supplier (whether such provider or supplier is initially enrolling in the program or is renewing such enrollment):

(A) Screening under paragraph (2).

(B) Enhanced oversight periods under paragraph (3).

(C) Enrollment moratoria under paragraph (4).

In applying this subsection for purposes of title XIX and XXI the Secretary may require a State to carry out the provisions of this subsection as a requirement of the State plan under title XIX or the child health plan under title XXI. Actions taken and determinations made under this subsection shall not be subject to review by a judicial tribunal.

(2) SCREENING.—For purposes of paragraph (1), the Secretary shall establish procedures under which screening is conducted with respect to providers of services and suppliers described in such paragraph. Such screening may include—

(A) licensing board checks;

(B) screening against the list of individuals and entities excluded from the program under title XVIII, XIX, or XXI;

(C) the excluded provider list system;

(D) background checks; and

(E) unannounced pre-enrollment or other site visits.

(3) ENHANCED OVERSIGHT PERIOD.—For purposes of paragraph (1), the Secretary shall establish procedures to provide for a period of not less than 30 days and not more than 365 days during which providers of services and suppliers described in such paragraph, as the Secretary determines appropriate, would be subject to enhanced oversight, such as required or unannounced (or required and unannounced) site visits or inspections, prepayment review, enhanced review of claims, and such other actions as specified by the Secretary, under the programs under titles XVIII, XIX, and XXI. Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that after the initial period such additional period of oversight is necessary.

(4) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—For purposes of paragraph (1), the Secretary, based upon a finding of a risk of serious ongoing fraud within a program under title XVIII, XIX, or XXI, may impose a moratorium on the enrollment of providers of services and suppliers within a category of providers of services and suppliers (including a category within a specific geographic area) under such title. Such a moratorium may only be imposed if the Secretary makes a determination that the moratorium would not adversely impact access of individuals to care under such program.

(5) CLARIFICATION.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider screening or enhanced provider oversight activities beyond those required by the Secretary.

(b) ENHANCED PROGRAM DISCLOSURE REQUIREMENTS.—

(1) DISCLOSURE.—A provider of services or supplier who submits on or after July 1, 2011, an application for enrollment and renewing enrollment in a program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that has uncollected debt or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

(2) ENHANCED SAFEGUARDS.—If the Secretary determines that such previous affiliation of such provider or supplier poses a risk of fraud, waste, or abuse, the Secretary may apply such enhanced safeguards as the Secretary determines necessary to reduce such risk associated with such provider or supplier enrolling or participating in the program under title XVIII, XIX, or XXI. Such safeguards may include enhanced oversight, such as enhanced screening of claims, required or unannounced (or re-

quired and unannounced) site visits or inspections, additional information reporting requirements, and conditioning such enrollment on the provision of a surety bond.

(3) AUTHORITY TO DENY PARTICIPATION.—If the Secretary determines that there has been at least one such affiliation and that such affiliation or affiliations, as applicable, of such provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary may deny the application of such provider or supplier.

(c) REPORTS ON AND REPAYMENT OF OVERPAYMENTS IDENTIFIED THROUGH INTERNAL AUDITS AND REVIEWS.—

(1) REPORTING AND RETURNING OVERPAYMENTS.—If a person knows of an overpayment, the person must—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and

(B) notify the Secretary, the State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) TIMING.—An overpayment must be reported and returned under paragraph (1)(A) by not later than the date that is 60 days after the date the person knows of the overpayment.

Any known overpayment retained later than the applicable date specified in this paragraph creates an obligation as defined in section 3729(b)(3) of title 31 of the United States Code.

(3) CLARIFICATION.—Repayment of any overpayments (or refunding by withholding of future payments) by a provider of services or supplier does not otherwise limit the provider or supplier's potential liability for administrative obligations such as applicable interests, fines, and specialties or civil or criminal sanctions involving the same claim if it is determined later that the reason for the overpayment was related to fraud by the provider or supplier or the employees or agents of such provider or supplier.

(4) DEFINITIONS.—In this subsection:

(A) KNOWS.—The term "knows" has the meaning given the terms "knowing" and "knowingly" in section 3729(b) of title 31 of the United States Code.

(B) OVERPAYMENT.—The term "overpayment" means any finally determined funds that a person receives or retains under title XVIII, XIX, or XXI to which the person, after applicable reconciliation, is not entitled under such title.

(C) PERSON.—The term "person" means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)), but excluding a beneficiary.

(d) ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.—For purposes of law enforcement activity, and to the extent consistent with applicable disclosure, privacy, and security laws, including the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1974, and subject to any information systems security requirements enacted by law or otherwise required by the Secretary, the Attorney General shall have

access, facilitation by the Inspector General of the Department of Health and Human Services, to claims and payment data relating to titles XVIII and XIX, in consultation with the Centers for Medicare & Medicaid Services or the owner of such data.

SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS' FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHIP AND WITH ENTITIES THAT BILL FOR SERVICES UNDER MEDICARE.

(a) REPORTING OF PAYMENTS OR OTHER TRANSFERS OF VALUE.—

(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011 and annually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request of or designated on behalf of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier.

(B) With respect to the payment or other transfer of value, other than a drug sample—

(i) its value and date;

(ii) the name of the related drug, device, or supply, if available; and

(iii) a description of its form, indicated (as appropriate for all that apply) as—

(I) cash or a cash equivalent;

(II) in-kind items or services;

(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

(IV) any other form (as defined by the Secretary).

(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

(3) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENTS.—In the case of a payment or other transfer of value made to a covered recipient by

an applicable manufacturer or distributor pursuant to a product development agreement for services furnished in connection with the development of a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report the value and recipient of such payment or other transfer of value in the first reporting period under this subsection in the next reporting deadline after the earlier of the following:

(A) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

(B) Two calendar years after the date such payment or other transfer of value was made.

(5) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO CLINICAL INVESTIGATIONS.—In the case of a payment or other transfer of value made to a covered recipient by an applicable manufacturer or distributor in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the applicable manufacturer or distributor may report as required under this section in the next reporting period under this subsection after the earlier of the following:

(A) The date that the clinical investigation is registered on the website maintained by the National Institutes of Health pursuant to section 671 of the Food and Drug Administration Amendments Act of 2007.

(B) Two calendar years after the date such payment or other transfer of value was made.

(6) CONFIDENTIALITY.—Information described in paragraph (4) or (5) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until or after the date on which the information is made available to the public under such paragraph.

(b) REPORTING OF OWNERSHIP INTEREST BY PHYSICIANS IN HOSPITALS AND OTHER ENTITIES THAT BILL MEDICARE.—Not later than March 31 of each year (beginning with 2011), each hospital or other health care entity (not including a Medicare Advantage organization) that bills the Secretary under part A or part B of title XVIII for services shall report on the ownership shares (other than ownership shares described in section 1877(c)) of each physician who, directly or indirectly, owns an interest in the entity. In this subsection, the term "physician" includes a physician's immediate family members (as defined for purposes of section 1877(a)).

(c) PUBLIC AVAILABILITY.—

(1) IN GENERAL.—The Secretary shall establish procedures to ensure that, not later than September 30, 2011, and on June 30 of each year beginning thereafter, the information submitted under subsections (a) and (b), other than information regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

(A) is searchable and is in a format that is clear and understandable;

(B) contains information that is presented by the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the

value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

(C) contains information that is able to be easily aggregated and downloaded;

(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year;

(E) contains background information on industry-physician relationships;

(F) in the case of information submitted with respect to a payment or other transfer of value described in subsection (a)(5), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

(G) contains any other information the Secretary determines would be helpful to the average consumer; and

(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to the covered recipient.

(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the applicable manufacturer or distributor of a covered drug, device, biological, or medical supply reporting under subsection (a) or hospital or other health care entity reporting physician ownership under subsection (b). The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the manufacturer, distributor, hospital, or other entity reporting under subsection (a) or (b) with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

(3) SPECIAL RULE FOR DRUG SAMPLES.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

(4) SPECIAL RULE FOR NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

(d) PENALTIES FOR NONCOMPLIANCE.—

(1) FAILURE TO REPORT.—

(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any applicable manufacturer or distributor that fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection, and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations promulgated to carry out such subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or distributor or other entity shall not exceed $150,000.

(2) KNOWING FAILURE TO REPORT.—

(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or distributor that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with regulations promulgated to carry out such subsection and any hospital or other entity that fails to submit information required under subsection (b) in a timely manner in accordance with regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) or (b) by an applicable manufacturer, distributor, or entity shall not exceed $1,000,000, or, if greater, 0.1 percentage of the total annual revenues of the manufacturer, distributor, or entity.

(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary of an intent to proceed under this paragraph in a specific case and providing the Secretary with an opportunity to bring an action under this subsection and the Secretary declining such opportunity, may proceed under this subsection against a manufacturer or distributor in the State.

(e) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(1) The information submitted under this section during the preceding year, aggregated for each applicable manufacturer or distributor of a covered drug, device, biological, or medical supply that submitted such information during such year.

(2) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(f) DEFINITIONS.—In this section:

(1) APPLICABLE MANUFACTURER; APPLICABLE DISTRIBUTOR.—The term "applicable manufacturer" means a manufacturer of a covered drug, device, biological, or medical supply, and the term "applicable distributor" means a distributor of a covered drug, device, or medical supply.

(2) CLINICAL INVESTIGATION.—The term "clinical investigation" means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

(3) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term "covered" means, with respect to a drug, device, biological, or medical supply, such a drug, device, biological, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(4) COVERED RECIPIENT.—The term "covered recipient" means the following:

(A) A physician.

(B) A physician group practice.

(C) Any other prescriber of a covered drug, device, biological, or medical supply.

(D) A pharmacy or pharmacist.

(E) A health insurance issuer, group health plan, or other entity offering a health benefits plan, including any employee of such an issuer, plan, or entity.

(F) A pharmacy benefit manager, including any employee of such a manager.

(G) A hospital.

(H) A medical school.

(I) A sponsor of a continuing medical education program.

(J) A patient advocacy or disease specific group.

(K) A organization of health care professionals.

(L) A biomedical researcher.

(M) A group purchasing organization.

(5) DISTRIBUTOR OF A COVERED DRUG, DEVICE, OR MEDICAL SUPPLY.—The term "distributor of a covered drug, device, or medical supply" means any entity which is engaged in the marketing or distribution of a covered drug, device, or medical supply (or any subsidiary of or entity affiliated with such entity), but does not include a wholesale pharmaceutical distributor.

(6) EMPLOYEE.—The term "employee" has the meaning given such term in section 1877(h)(2).

(7) KNOWINGLY.—The term "knowingly" has the meaning given such term in section 3729(b) of title 31, United States Code.

(8) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term "manufacturer of a covered drug, device, biological, or medical supply" means any entity which is engaged in the production, preparation, propagation, compounding, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply (or any subsidiary of or entity affiliated with such entity).

(9) PAYMENT OR OTHER TRANSFER OF VALUE.—

(A) IN GENERAL.—The term "payment or other transfer of value" means a transfer of anything of value for or of any of the following:

(i) Gift, food, or entertainment.

(ii) Travel or trip.

(iii) Honoraria.

(iv) Research funding or grant.

(v) Education or conference funding.

(vi) Consulting fees.

(vii) Ownership or investment interest and royalties or license fee.

(B) INCLUSIONS.—Subject to subparagraph (C), the term "payment or other transfer of value" includes any compensation, gift, honorarium, speaking fee, consulting fee, travel, services, dividend, profit distribution, stock or stock option grant, or any ownership or investment interest held by a physician in a manufacturer (excluding a dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund (as described in section 1877(c))).

(C) EXCLUSIONS.—The term "payment or other transfer of value" does not include the following:

(i) Any payment or other transfer of value provided by an applicable manufacturer or distributor to a covered recipient where the amount transferred to, requested by, or designated on behalf of the covered recipient does not exceed $5.

(ii) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(iii) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(iv) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(v) In-kind items used for the provision of charity care.

(vi) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

(vii) Compensation paid by a manufacturer or distributor of a covered drug, device, biological, or medical supply to a covered recipient who is directly employed by and works solely for such manufacturer or distributor.

(viii) Any discount or cash rebate.

(10) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r). For purposes of this section, such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

(g) ANNUAL REPORTS TO STATES.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to States a report that includes a summary of the information submitted under subsections (a) and (d) during the preceding year with respect to covered recipients or other hospitals and entities in the State.

(h) RELATION TO STATE LAWS.—

(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

(2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Paragraph (1) shall not preempt any law or regulation of a State or of a political subdivision of a State that requires any of the following:

(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

(B) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

(C) The discovery or admissibility of information described in this section in a criminal, civil, or administrative proceeding.

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SEC. 1138A. REQUIREMENT FOR PUBLIC REPORTING BY HOSPITALS AND AMBULATORY SURGICAL CENTERS ON HEALTH CARE-ASSOCIATED INFECTIONS.

(a) REPORTING REQUIREMENT.—

(1) IN GENERAL.—The Secretary shall provide that a hospital (as defined in subsection (g)) or ambulatory surgical center meeting the requirements of titles XVIII or XIX may participate in the programs established under such titles (pursuant to the applicable provisions of law, including sections 1866(a)(1) and 1832(a)(1)(F)(i)) only if, in accordance with this section, the hospital or center reports such information on health care-associated infections that develop in the hospital or center (and such demographic information associated with such infections) as the Secretary specifies.

(2) REPORTING PROTOCOLS.— Such information shall be reported in accordance with reporting protocols established by the Secretary through the Director of the Centers for Disease Control and Prevention (in this section referred to as the "CDC") and to the National Healthcare Safety Network of the CDC or under such another reporting system of such Centers as determined appropriate by the Secretary in consultation with such Director.

(3) COORDINATION WITH HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is coordinated with systems established under the HITECH Act, where appropriate.

(4) PROCEDURES TO ENSURE THE VALIDITY OF INFORMATION.— The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall address failures to report as well as errors in reporting.

(5) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of CDC, shall promulgate regulations to carry out this section.

(b) PUBLIC POSTING OF INFORMATION.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

(1) among hospitals and ambulatory surgical centers; and

(2) by demographic information.

(c) ANNUAL REPORT TO CONGRESS.—On an annual basis the Secretary shall submit to the Congress a report that summarizes each of the following:

(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year.

(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

(3) Based on the most recent information available to the Secretary on the composition of the professional staff of hospitals and ambulatory surgical centers, the number of certified infection control professionals on the staff of hospitals and ambulatory surgical centers.

(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

(d) NON-PREEMPTION OF STATE LAWS.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information on health

care-associated infections or patient safety procedures for a hospital or ambulatory surgical center.

(e) HEALTH CARE-ASSOCIATED INFECTION.—For purposes of this section:

(1) IN GENERAL.—The term "health care-associated infection" means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

(2) RELATED TO RECEIVING HEALTH CARE.—The term "related to receiving health care", with respect to an infection, means that the infection was not incubating or present at the time health care was provided.

(f) APPLICATION TO CRITICAL ACCESS HOSPITALS.—For purposes of this section, the term "hospital" includes a critical access hospital, as defined in section 1861(mm)(1).

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IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (e)). The office or program shall—

(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A and B of title XVIII, under the Medicare Advantage program under part C of such title, and under title XIX;

(2) identify areas of such policies where better coordination and protection could improve care and costs; and

(3) issue guidance to States regarding improving such coordination and protection.

(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

(2) Development of methods to facilitate access to post-acute and community-based services and to identify actions that could lead to better coordination of community-based care.

(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income subsidy program under section

1860D–14 to identify methods to more efficiently and effectively reach and enroll dual eligibles.

(4) An assessment of communication strategies for dual eligibles to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1–800–MEDICARE, and the Medicare handbook.

(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors related to enrollee satisfaction with services and care delivery.

(6) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

(7) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

(8) Coordination of activities relating to Medicare Advantage plans under 1859(b)(6)(B)(ii) and Medicaid.

(d) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit to Congress a report on progress in activities conducted under this section.

(e) DEFINITIONS.—In this section:

(1) DUAL ELIGIBLE.—The term "dual eligible" means an individual who is dually eligible for benefits under title XVIII, and medical assistance under title XIX, including such individuals who are eligible for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

(2) MEDICARE; MEDICAID.—The terms "Medicare" and "Medicaid" mean the programs under titles XVIII and XIX, respectively.

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PART C—ADMINISTRATIVE SIMPLIFICATION

DEFINITIONS

SEC. 1171. For purposes of this part:

(1) * * *

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(7) STANDARD.—The term "standard", when used [with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.] *with reference to a transaction or data element of health information in section 1173 means implementation specifications, certification criteria, operating rules, messaging formats, codes, and code sets adopted or established by the Secretary for the electronic exchange and use of information.*

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

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

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

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

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SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

(a) STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

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

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

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

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

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

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

(E) enable, where feasible, near real-time adjudication of claims;

(F) provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction deemed appropriate by the Secretary;

(G) describe all data elements (such as reason and remark codes) in unambiguous terms, not permit optional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions; and

(H) harmonize all common data elements across administrative and clinical transaction standards.

(3) TIME FOR ADOPTION.—Not later than 2 years after the date of implementation of the X12 Version 5010 transaction standards implemented under this part, the Secretary shall adopt standards under this section.

(4) REQUIREMENTS FOR SPECIFIC STANDARDS.—The standards under this section shall be developed, adopted, and enforced so as to—

(A) clarify, refine, complete, and expand, as needed, the standards required under section 1173;

(B) require paper versions of standardized transactions to comply with the same standards as to data content such that a fully compliant, equivalent electronic transaction can be populated from the data from a paper version;

(C) enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice;

(D) require timely and transparent claim and denial management processes, including tracking, adjudication, and appeal processing ;

(E) require the use of a standard electronic transaction with which health care providers may quickly and efficiently enroll with a health plan to conduct the other electronic transactions provided for in this part; and

(F) provide for other requirements relating to administrative simplification as identified by the Secretary, in consultation with stakeholders.

(5) BUILDING ON EXISTING STANDARDS.—In developing the standards under this section, the Secretary shall build upon existing and planned standards.

(6) IMPLEMENTATION AND ENFORCEMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

(A) a process and timeframe with milestones for developing the complete set of standards;

(B) an expedited upgrade program for continually developing and approving additions and modifications to the standards as often as annually to improve their quality and extend their functionality to meet evolving requirements in health care;

(C) programs to provide incentives for, and ease the burden of, implementation for certain health care providers, with special consideration given to such providers serving rural or underserved areas and ensure coordination with standards, implementation specifications, and certification criteria being adopted under the HITECH Act;

(D) programs to provide incentives for, and ease the burden of, health care providers who volunteer to participate in the process of setting standards for electronic transactions;

(E) an estimate of total funds needed to ensure timely completion of the implementation plan; and

(F) an enforcement process that includes timely investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for non-compliance consistent with existing laws and regulations, and a

fair and reasonable appeals process building off of enforcement provisions under this part.

(b) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

(c) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are—

(1) used and disclosed in a manner that meets the HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), including any privacy or security standard adopted under section 3004 of such Act; and

(2) protected from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

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PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS

SEC. 1179. To the extent that an entity is engaged in activities of a financial institution (as defined in section 1101 of the Right to Financial Privacy Act of 1978) *on behalf of an individual*, [or is engaged] *and is engaged* in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution *on behalf of an individual (other than as a business associate for a covered entity)*, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities, including the following:

(1) The use or disclosure of information by the entity for authorizing, processing, clearing, settling, billing, transferring, reconciling or collecting, a payment for, or related to, health plan premiums or health care, where such payment is made by any means, including a credit, debit, or other payment card, an account, check, or electronic funds transfer.

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PART D—COMPARATIVE EFFECTIVENESS RESEARCH

COMPARATIVE EFFECTIVENESS RESEARCH

SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

(1) IN GENERAL.—The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the "Center") to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

(2) DUTIES.—The Center shall—

(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2); and

(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data.

(3) POWERS.—

(A) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Center, the head of that department or agency shall furnish that information to the Center on an agreed upon schedule.

(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(iii) adopt procedures allowing any interested party to submit information for the use by the Center and Commission under subsection (b) in making reports and recommendations.

(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

(D) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the "Commission") to oversee and evaluate the activities carried out by the Center under subsection (a), subject to the authority of the Secretary, to ensure such activities result in highly credible research and information resulting from such research.

(2) DUTIES.—The Commission shall—

(A) determine national priorities for research described in subsection (a) and in making such determinations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

(D) review the methodologies developed by the center under subsection (a)(2)(C);

(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

(G) make recommendations for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall consult with patients and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders; and

(K) make recommendations to the center for the broad dissemination of the findings of research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value.

(3) COMPOSITION OF COMMISSION.—

(A) IN GENERAL.—The members of the Commission shall consist of—

(i) the Director of the Agency for Healthcare Research and Quality;

(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

(iii) 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

Of such members, at least 9 shall be practicing physicians, health care practitioners, consumers, or patients.

(B) QUALIFICATIONS.—

(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

(I) Epidemiology.

(II) Health services research.

(III) Bioethics.

(IV) Decision sciences.

(V) Health disparities.

(VI) Economics.

(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

(I) Patients.

(II) Health care consumers.

(III) Practicing Physicians, including surgeons.

(IV) Other health care practitioners engaged in clinical care.

(V) Employers.

(VI) Public payers.

(VII) Insurance plans.

(VIII) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

(C) LIMITATION.—No more than 3 of the Members of the Commission may be representatives of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(VIII).

(4) APPOINTMENT.—

(A) IN GENERAL.—The Secretary shall appoint the members of the Commission.

(B) CONSULTATION.—In considering candidates for appointment to the Commission, the Secretary may consult with the Government Accountability Office and the Institute of Medicine of the National Academy of Sciences.

(5) CHAIRMAN; VICE CHAIRMAN.—The Secretary shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Secretary may designate another member for the remainder of that member's term. The Chairman shall serve as an ex officio member of the National Advisory Council of the Agency for Health Care Re-

search and Quality under section 931(c)(3)(B) of the Public Health Service Act.

(6) TERMS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

(i) 8 shall be appointed for a term of 4 years; and

(ii) 7 shall be appointed for a term of 3 years.

(7) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

(8) CONFLICTS OF INTEREST.—

(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(H), the Secretary or the Commission, respectively, shall take into consideration any financial interest (as defined in subparagraph (D)), consistent with this paragraph, and develop a plan for managing any identified conflicts.

(B) EVALUATION AND CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described paragraph (2)(H) the Secretary or the Commission shall review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(iii) for service on the Commission at a meeting of the Commission.

(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

(i) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Commission or a clinical perspective advisory panel described in paragraph (2)(H) regarding a "particular matter" (as that term is used in section 208 of title 18, United States Code), each member of the Commission or the clinical perspective advisory panel who is a full-time Government employee or special Government employee shall disclose to the Secretary financial interests in accordance with subsection (b) of such section 208.

(ii) PROHIBITIONS ON PARTICIPATION.—Except as provided under clause (iii), a member of the Commission or a clinical perspective advisory panel described in paragraph (2)(H) may not participate with respect to a particular matter considered in meeting of the Commission or the clinical perspective advisory panel if

such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the Government officers or employees to which such regulations apply.

(iii) WAIVER.—If the Secretary determines it necessary to afford the Commission or a clinical perspective advisory panel described in paragraph 2(H) essential expertise, the Secretary may grant a waiver of the prohibition in clause (ii) to permit a member described in such subparagraph to—

(I) participate as a non-voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting; or

(II) participate as a voting member with respect to a particular matter considered in a Commission or a clinical perspective advisory panel meeting.

(iv) LIMITATION ON WAIVERS AND OTHER EXCEPTIONS.—

(I) DETERMINATION OF ALLOWABLE EXCEPTIONS FOR THE COMMISSION.—The number of waivers granted to members of the Commission cannot exceed one-half of the total number of members for the Commission.

(II) PROHIBITION ON VOTING STATUS ON CLINICAL PERSPECTIVE ADVISORY PANELS.—No voting member of any clinical perspective advisory panel shall be in receipt of a waiver. No more than two non-voting members of any clinical perspective advisory panel shall receive a waiver.

(D) FINANCIAL INTEREST DEFINED.—For purposes of this paragraph, the term "financial interest" means a financial interest under section 208(a) of title 18, United States Code.

(9) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Commission, the Commission may—

(A) appoint an Executive Director (subject to the approval of the Secretary) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as

may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(D) make advance, progress, and other payments which relate to the work of the Commission;

(E) provide transportation and subsistence for persons serving without compensation; and

(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

(B) Methods of conducting such research shall be scientifically based.

(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings of such research.

(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall consider advice given to the Center by the clinical perspective advisory panel for the national research priority.

(3) STAKEHOLDER INPUT.—

(A) IN GENERAL.—The Commission shall consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission.

(B) SPECIFIC AREAS OF CONSULTATION.—Consultation shall include where deemed appropriate by the Commission—

(i) recommending research priorities and questions;

(ii) recommending research methodologies; and

(iii) advising on and assisting with efforts to disseminate research findings.

(C) OMBUDSMAN.—The Secretary shall designate a patient ombudsman. The ombudsman shall—

(i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center; and

(ii) ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Commission.

(4) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

(A) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care items and services used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), and individuals with different comorbidities; and—

(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by the Center or a grantee or contractor of the Center:

(A) Any interim or progress reports as deemed appropriate by the Secretary.

(B) Stakeholder comments.

(C) A final report.

(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center shall—

(A) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions;

(B) discuss findings and other considerations specific to certain sub-populations, risk factors, and comorbidities as appropriate;

(C) include considerations such as limitations of research and what further research may be needed, as appropriate;

(D) not include any data that the dissemination of which would violate the privacy of research participants or violate

any confidentiality agreements made with respect to the use of data under this section; and

(E) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation.

(2) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Center shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use and incorporation of such findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions regarding medical items and services. In developing and adopting such protocols and strategies, the Center shall consult with stakeholders concerning the types of dissemination that will be most useful to the end users of information and may provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.

(f) REPORTS TO CONGRESS.—

(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section. Each such report shall include a discussion of the Center's compliance with subsection (c)(4)(B), including any reasons for lack of compliance with such subsection.

(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

(3) ANALYSIS AND REVIEW.—Not later than December 31, 2013, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the Commission but not funded.

(g) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the "CERTF") under section 9511 of the Internal Revenue Code of 1986 shall be available, without the need for further appropriations and without fiscal year limitation, to the Secretary to carry out this section.

(h) CONSTRUCTION.—Nothing in this section shall be construed to permit the Commission or the Center to mandate coverage, reimbursement, or other policies for any public or private payer.

PART E—QUALITY IMPROVEMENT

ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic diseases;

(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

(3) have the greatest potential for improving the performance, affordability, and patient-centeredness of health care, including those due to variations in care;

(4) address health disparities across groups and areas; and

(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

(d) DEFINITIONS.—In this part:

(1) CONSENSUS-BASED ENTITY.—The term "consensus-based entity" means an entity with a contract with the Secretary under section 1890.

(2) QUALITY MEASURE.—The term "quality measure" means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.

SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.

(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

(3) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

(A) seek public input; and

(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

(c) DEVELOPMENT OF QUALITY MEASURES.—

(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—Quality measures developed under agreements under subsection (a) shall be designed—

(A) to assess outcomes and functional status of patients;

(B) to assess the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

(C) to assess patient experience and patient engagement;

(D) to assess the safety, effectiveness, and timeliness of care;

(E) to assess health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language;

(F) to assess the efficiency and resource use in the provision of care;

(G) to the extent feasible, to be collected as part of health information technologies supporting better delivery of health care services;

(H) to be available free of charge to users for the use of such measures; and

(I) to assess delivery of health care services to individuals regardless of age.

(2) AVAILABILITY OF MEASURES.—The Secretary shall make quality measures developed under this section available to the public.

(3) TESTING OF PROPOSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.

(4) UPDATING OF ENDORSED MEASURES.—The Secretary may use amounts made available under subsection (f) to fund the updating (and testing, if applicable) by consensus-based entities of quality measures that have been previously endorsed by such an entity as new evidence is developed, in a manner consistent with section 1890(b)(3).

(d) QUALIFIED ENTITIES.—Before entering into agreements with a qualified entity, the Secretary shall ensure that the entity is a public, nonprofit or academic institution with technical expertise in the area of health quality measurement.

(e) APPLICATION FOR GRANT.—A grant may be made under this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $25,000,000, to the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.

(2) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $25,000,000 for each of the fiscal years 2010 through 2014.

SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

(a) GAO EVALUATIONS.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary.

(b) CONSIDERATIONS.—In carrying out the evaluation under subsection (a), the Comptroller General shall determine—

(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;

(2) whether data collection efforts under the system use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients' personal health information and provides data security;

(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and correct findings; and

(4) the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.

(c) REPORT.—The Comptroller General shall submit reports to Congress and to the Secretary containing a description of the findings and conclusions of the results of each such evaluation.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PROVISIONS RELATING TO ADMINISTRATION

SEC. 1808. (a) * * *

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(d) MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.—

(1) LIST OF MEASURES.—Not later than December 1 before each year (beginning with 2011), the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the calendar year following such year, as the case may be.

(2) CONSULTATION ON SELECTION OF ENDORSED QUALITY MEASURES.—A consensus-based entity that has entered into a contract under section 1890 shall, as part of such contract, convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in public health care programs.

(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.

(4) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (2) with respect to the selection of quality measures, the consensus-based entity described in such paragraph shall provide for an open and transparent process for the activities conducted pursuant to such convening.

(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under paragraph (2) shall ensure that the selection of representatives of multi-stakeholder groups includes provision for public nominations for, and the opportunity for public comment on, such selection.

(5) USE OF INPUT.—The respective proposed rule shall contain a summary of the recommendations made by the multi-stakeholder groups under paragraph (2), as well as other comments received regarding the proposed measures, and the extent to which such proposed rule follows such recommendations and the rationale for not following such recommendations.

(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term "multi-stakeholder groups" means, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

(A) Hospitals and other institutional providers.

(B) Physicians.

(C) Health care quality alliances.

(D) Nurses and other health care practitioners.

(E) Health plans.

(F) Patient advocates and consumer groups.

(G) Employers.

(H) Public and private purchasers of health care items and services.

(I) Labor organizations.

(J) Relevant departments or agencies of the United States.

(K) Biopharmaceutical companies and manufacturers of medical devices.

(L) Licensing, credentialing, and accrediting bodies.

(7) FUNDING.—

(A) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.

(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the provisions of this subsection, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

SEC. 1814. (a) REQUIREMENT OF REQUESTS AND CERTIFICATIONS.—Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the [period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;] *period of 1 calendar year from which such services are furnished; and*

(2) a physician, *in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),* or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a di-

rect or indirect employment relationship with the facility but is working in collaboration with a physician, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

* * * * * * *

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; [and such services] *such services* are or were furnished while the individual was under the care of a physician*, and, in the case of a certification or recertification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary*; or

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence,

service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. *In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.*

* * * * * * *

(i) PAYMENT FOR HOSPICE CARE.—(1)(A) * * *

* * * * * * *

(C)(i) * * *

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—

(I) * * *

* * * * * * *

(VII) for a subsequent fiscal year, the market basket percentage increase *(which is subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))* for the fiscal year.

* * * * * * *

(l) PAYMENT FOR INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—(1) * * *

* * * * * * *

(5) The adjustment factor described in section 1886(p)(3) shall apply to payments with respect to a critical access hospital with respect to a cost reporting period beginning in fiscal year 2012 and each subsequent fiscal year (after application of paragraph (4) of this subsection) in a manner similar to the manner in which such

section applies with respect to a fiscal year to an applicable hospital as described in section 1886(p)(2).

[(5)**]** *(6)* There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) * * *

* * * * * * *

(C) the specification of EHR reporting periods under section 1886(n)(6)(B) as applied under paragraphs (3) and (4); **[**and**]**

(D) the identification of costs for purposes of paragraph (3)(C)**[**.**]***; and*

(E) the methodology for determining the adjustment factor under paragraph (5), including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmissions.

* * * * * * *

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

* * * * * * *

(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) * * *

* * * * * * *

(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary *for activities described in paragraph (3)(C) and* to carry out the Medicare Integrity Program under section 1893, subject to subparagraphs (B), (C), and (D) and to be available without further appropriation *until expended*.

* * * * * * *

(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $100,000,000 to such Account from such Trust Fund for each fiscal year beginning with 2011. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

* * * * * * *

REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES

SEC. 1819. (a) * * *

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) * * *

(B) QUALITY ASSESSMENT AND [ASSURANCE] *ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.*—

(i) IN GENERAL.—A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which [(i)] *(I)* meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and [(ii)] *(II)* develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the "QAPI program") for skilled nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a skilled nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.

* * * * * * *

(8) INFORMATION ON NURSE STAFFING.—

(A) * * *

* * * * * * *

(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a skilled nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and

auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

(ii) include resident census data and information on resident case mix;

(iii) include a regular reporting schedule; and

(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) * * *

* * * * * * *

(7) NOTIFICATION OF FACILITY CLOSURE.—

(A) IN GENERAL.—Any individual who is the administrator of a skilled nursing facility must—

(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

(B) RELOCATION.—

(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been

successfully relocated to another facility or an alternative home and community-based setting.

(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(A) * * *

[(B) REQUIRED NOTICES.—If a change occurs in—

[(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

[(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

[(iii) the corporation, association, or other company responsible for the management of the facility, or

[(iv) the individual who is the administrator or director of nursing of the facility,—the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.]

[(C)] *(B)* SKILLED NURSING FACILITY ADMINISTRATOR.—The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(C) COMPLIANCE AND ETHICS PROGRAMS.—

(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a skilled nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the "operating organization" or "organization"), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

(ii) DEVELOPMENT OF REGULATIONS.—

(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a

program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements shall specifically apply to the corporate level management of multi-unit nursing home chains.

(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term "compliance and ethics program" means, with respect to a skilled nursing facility, a program of the operating organization that—

(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(II) includes at least the required components specified in clause (iv).

(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a skilled nursing facility in lieu of section 1874(d).

(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

* * * * * * *

(e) STATE REQUIREMENTS RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—The requirements, referred to in section 1864(d), with respect to a State are as follows:

(1) * * *

* * * * * * *

(6) COMPLAINT PROCESSES AND WHISTLE-BLOWER PROTECTION.—

(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(9) available upon request to—

(i) a resident of a skilled nursing facility;

(ii) any person acting on the resident's behalf; and

(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the skilled nursing facility, that the legal representative of a resident of a skilled nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(C) WHISTLEBLOWER PROTECTION.—

(i) PROHIBITION AGAINST RETALIATION.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(9) or some other method for submitting the complaint.

(ii) RETALIATORY REPORTING.—A skilled nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated , or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and such other relief as the court deems just and proper.

(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(9) (including submitting a complaint orally).

(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

(i) the information reported or disclosed in the complaint is true; and

(ii) the violation of this title has occurred or may occur in relation to such information.

(f) RESPONSIBILITIES OF SECRETARY RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—

(1) * * *

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum *(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)*, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

* * * * * * *

(8) SPECIAL FOCUS FACILITY PROGRAM.—

(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(9) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a skilled nursing facility.

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) * * *

* * * * * * *

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) * * *

* * * * * * *

(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall

submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) ENFORCEMENT PROCESS.—

(1) * * *

(2) SECRETARIAL AUTHORITY.—

(A) * * *

(B) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) * * *

[(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term "applicable per instance amount" means—

(aa) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

(bb) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

(cc) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

(III) APPLICABLE PER DAY AMOUNT.—In this clause, the term "applicable per day amount" means—

(aa) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (III)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in subclause (II)(bb).

(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

(VII) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

(aa) subject to item (cc), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such

amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

(VIII) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or ⟦the Secretary shall terminate⟧ *the Secretary, subject to subsection (c)(7), shall terminate* the facility's participation under this title. If the facility's participation under this title is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this title consistent with the requirements of ⟦subsection (c)(2)⟧ *paragraphs (2) and (7) of subsection (c).*

(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), *(ii),* and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

* * * * * * *

(i) NURSING HOME COMPARE WEBSITE.—

(1) INCLUSION OF ADDITIONAL INFORMATION.—

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the "Nursing Home Compare" Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Information that is reported to the Secretary under section 1124(c)(4).

(ii) Information on the "Special Focus Facility program" (or a successor program) established by the Centers for Medicare and Medicaid Services, according to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

(I) were newly enrolled in the program;

(II) are enrolled in the program and have failed to significantly improve;

(III) are enrolled in the program and have significantly improved;

(IV) have graduated from the program; and

(V) have closed voluntarily or no longer participate under this title.

(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting "nursing home staff hours per resident day");

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(iv) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

(v) The standardized complaint form developed under subsection (f)(8), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

(B) DEADLINE FOR PROVISION OF INFORMATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

(2) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

[(i)] *(j)* CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section 1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

(a) IN GENERAL.—If the Secretary determines on the basis of a survey or otherwise, that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and failed to meet such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

(1) that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in subsection (b)(2)(A); or

(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may—

(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

(b) INTERMEDIATE SANCTIONS.—

(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2012—

(A) a range of intermediate sanctions to apply to hospice programs under the conditions described in subsection (a), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2) SPECIFIED SANCTIONS.—

(A) IN GENERAL.—The intermediate sanctions developed under paragraph (1) may include—

(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000,

(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

(iii) the appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made,

(iv) corrective action plans, and

(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all requirements referred to in that clause.

(B) CLARIFICATION.—The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

(3) SECRETARIAL AUTHORITY.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) * * *

* * * * * * *

(iv) services of a nurse practitioner or clinical nurse specialist but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services; [and]

(v) marriage and family therapist services; and

(vi) mental health counselor services;

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section [1861(s)(10)(A)] *1861(s)(10)*, the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed

for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),

(G) * * *

(H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph **[**(but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician)**]**, (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if

performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz))) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5), ⟦and⟧ (W) with respect to additional preventive services (as defined in section 1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D), and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph*, (X) with respect to marriage and family therapist services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L), and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L)*;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E),

(F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) * * *

* * * * * * *

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); [and]

(G) with respect to items and services described in section [1861(s)(10)(A)] *1861(s)(10)*, the lesser of—

(i) * * *

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); *and*

(H) with respect to additional preventive services (as defined in section 1861(ddd)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);

(3) in the case of services described in section 1832(a)(2)(D)—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section [1861(s)(10)(A)] *1861(s)(10)*) exceed 80 percent of such costs; or

* * * * * * *

With respect to Medicare covered preventive services (including services described in the last sentence of section 1833(b)), in any case in which the payment rate otherwise provided under this part is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for [items and services

described in section 1861(s)(10)(A)] *Medicare covered preventive services (as defined in section 1861(iii))*, (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), *and* (4) such deductible shall not apply to Federally qualified health center services, [(5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb)), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)), and] (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww)). The stotal amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year. *Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.*

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(g)(1) * * *

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(5) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on [December 31, 2009] *December 31, 2011*, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon

request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request, the Secretary shall be deemed to have found the services to be medically necessary.

(h)(1) * * *

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, **[**for each of the years 2009 through 2013**]** *for 2009*, 0.5 percentage points, and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) * * *

* * * * * * *

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, **[**and**]**

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent**[**.**]***; and*

(V) the annual adjustment in the fee schedules determined under clause (i) for years beginning with 2010 shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).

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(i)(1) * * *

(2)(A) * * *

* * * * * * *

(D)(i) * * *

* * * * * * *

(v) In implementing the system described in clause (i), for services furnished during 2010 or any subsequent year, to the extent that an annual percentage change factor applies, such factor shall be subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).

[(v)**]** *(vi)* There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system,

the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

* * * * * * *

(7)(A) * * *

(B) Except as the Secretary may otherwise provide, *subject to subparagraph (C),* the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of section 1833(t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(C) Under subparagraph (B) the Secretary shall require the reporting of such additional data relating to quality of services furnished in an ambulatory surgical facility, including data on health care associated infections, as the Secretary may specify.

(8) The Secretary shall require, as a condition of the agreement described in section 1832(a)(2)(F)(i), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.

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(m)(1) * * *

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(4) The provisions of this subsection shall not be taken into account in applying subsections (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

[(4)**]** *(5)* There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) * * *

* * * * * * *

(p) PRIMARY CARE PAYMENT INCENTIVES.—

(1) IN GENERAL.—In the case of primary care services (as defined in paragraph (2)) furnished on or after January 1, 2011, by a primary care practitioner (as defined in paragraph (3)) for which amounts are payable under section 1848, in addition to the amount otherwise paid under this part there shall also be paid to the practitioner (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal 5 percent (or 10 percent if the practitioner predominately furnishes such services in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a primary care health professional shortage area.

(2) PRIMARY CARE SERVICES DEFINED.—In this subsection, the term "primary care services"—

(A) means services which are evaluation and management services as defined in section 1848(j)(5)(A); and

(B) includes services furnished by another health care professional that would be described in subparagraph (A) if furnished by a physician.

(3) PRIMARY CARE PRACTITIONER DEFINED.—In this subsection, the term "primary care practitioner"—

(A) means a physician or other health care practitioner (including a nurse practitioner) who—

(i) specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology; and

(ii) has allowed charges for primary care services that account for at least 50 percent of the physician's or practitioner's total allowed charges under section 1848, as determined by the Secretary for the most recent period for which data are available; and

(B) includes a physician assistant who is under the supervision of a physician described in subparagraph (A).

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) any determination or designation under this subsection;

(B) the identification of services as primary care services under this subsection; and

(C) the identification of a practitioner as a primary care practitioner under this subsection.

(5) COORDINATION WITH OTHER PAYMENTS.—

(A) WITH OTHER PRIMARY CARE INCENTIVES.—The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) and any payment under such subsections shall not be taken into account in computing payments under this subsection.

(B) WITH QUALITY INCENTIVES.—Payments under this subsection shall not be taken into account in determining the amounts that would otherwise be paid under this part for purposes of section 1834(g)(2)(B).

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) * * *

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) * * *

* * * * * * *

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include ⟦screening mammography (as defined in section 1861(jj)) and diagnostic mammography⟧ *diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(iii)(1))*.

* * * * * * *

(3) CALCULATION OF BASE AMOUNTS.—

(A) * * *

* * * * * * *

(C) CALCULATION OF CONVERSION FACTORS.—

(i) * * *

* * * * * * *

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, subject to paragraph (17), the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) *(which is subject to the productivity adjustment described in subclause (II) of such section)* to hospital discharges occurring during the fiscal year ending in such year, reduced *(but not below 0)* by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

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(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) * * *

* * * * * * *

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN RURAL HOSPITALS.—(I) * * *

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, **[**2010**]** *2012*, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008 **[**or 2009**]***, 2009, 2010, or 2011*.

(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before **[**January 1, 2010**]** *January 1, 2012*, for which the PPS amount is less than the pre-BBA amount, the amount of pay-

ment under this subsection shall be increased by 85 percent of the amount of such difference.

* * * * * * *

(16) MISCELLANEOUS PROVISIONS.—

(A) * * *

* * * * * * *

(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before [January 1, 2010] *January 1, 2012*, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be included in determining any outlier payment under this subsection.

(17) QUALITY REPORTING.—

(A) * * *

* * * * * * *

(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1886(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to quality measures for inpatient hospital services.

(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

* * * * * * *

(x) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that

would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the services under this part.

(2) IDENTIFICATION OF EFFICIENT AREAS.—

(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending under this part and part A for services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to eliminate the effect of geographic adjustments in payment rates.

(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

(i) the identification of a county or other area under subparagraph (A); or

(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

* * * * * * *

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) * * *

* * * * * * *

(F) RENTAL CAP.—

(i) * * *

(ii) PAYMENTS AND RULES AFTER RENTAL CAP.—[After the] *Except as provided in clause (iii), after the* 36th continuous month during which payment is made for the equipment under this paragraph—

(I) * * *

* * * * * * *

(iii) CONTINUATION OF SUPPLY.—In the case of a supplier furnishing such equipment to an individual under this subsection as of the 27th month of the 36 months described in clause (i), the supplier furnishing such equipment as of such month shall continue to furnish such equipment to such individual (either directly or though arrangements with other suppliers of such equipment) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary, regardless of the location of the individual, unless another supplier has accepted responsibility for continuing to furnish such equipment during the remainder of such period.

(iv) EXCEPTION FOR BANKRUPTCY.—If a supplier who furnishes oxygen and oxygen equipment to an individual is declared bankrupt and its assets are liquidated and at the time of such declaration and liquidation more than 24 months of rental payments have been made, such individual may begin a new 36-month rental period under this subparagraph with another supplier of oxygen.

* * * * * * *

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) PAYMENT.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) * * *

* * * * * * *

(iii) PURCHASE AGREEMENT OPTION FOR *CERTAIN COMPLEX REHABILITATIVE* POWER-DRIVEN WHEELCHAIRS.—In the case of a [power-driven wheelchair] *complex rehabilitative power-driven wheelchair recognized by the Secretary as classified within group 3 or higher*, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

* * * * * * *

(11) IMPROPER BILLING AND REQUIREMENT OF PHYSICIAN ORDER.—

(A) * * *

(B) REQUIREMENT OF PHYSICIAN ORDER.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a [physician] *physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)* has communicated to the supplier, before delivery of the item, a written order for the item *and shall require that such an order be written pursuant to the physician documenting that the physician has had a face-to-face*

encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

* * * * * * *

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) * * *

* * * * * * *

(K) for 2010, 2011, 2012, and 2013, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year*, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)*;

(L) for 2014—

(i) in the case of items and services described in subparagraph (J)(i) for which a payment adjustment has not been made under subsection (a)(1)(F)(ii) in any previous year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013, *subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II),* plus 2.0 percentage points; or

(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013*, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)*; and

(M) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year*, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)*.

* * * * * * *

(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) * * *

* * * * * * *

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this

part. *The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy (i) that has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued (which may include renewal of) a provider number (as described in the first sentence of this paragraph) for at least 5 years, and (ii) for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed.*

* * * * * * *

(20) IDENTIFICATION OF QUALITY STANDARDS.—

(A) * * *

* * * * * * *

(F) APPLICATION OF ACCREDITATION REQUIREMENT.—In implementing quality standards under this paragraph—

(i) subject to [clause (ii)] *clauses (ii) and (iii)*, the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards; [and]

(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1848(k)(3)(B)), and including such other persons, such as orthotists and prosthetists, as specified by the Secretary, furnishing such items and services—

(I) * * *

(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services[.]*; and*

(iii) the requirement for accreditation described in clause (i) shall not apply for purposes of supplying diabetic testing supplies, canes, and crutches in the case of a pharmacy that is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies.

Any supplier that has submitted an application for accreditation before August 1, 2009, shall be deemed as meeting applicable standards and accreditation requirement under this subparagraph until such time as the independent accreditation organization takes action on the supplier's application.

* * * * * * *

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) * * *

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) * * *

* * * * * * *

(C) FACILITY PAYMENT LIMIT.—

(i) * * *

[(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

[(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

[(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).]

(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

* * * * * * *

(3) SCREENING COLONOSCOPY.—

(A) * * *

* * * * * * *

(C) FACILITY PAYMENT LIMIT.—

(i) * * *

[(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

[(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

[(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).]

(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

* * * * * * *

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) * * *

* * * * * * *

(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

(A) * * *

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased by the percentage increase in the

consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points *and, in the case of years beginning with 2010, subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)*.

* * * * * * *

(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and [before January 1, 2010] *before January 1, 2012* for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and [before January 1, 2010] *before January 1, 2012*); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and [before January 1, 2010] *before January 1, 2012*).

* * * * * * *

(m) PAYMENT FOR TELEHEALTH SERVICES.—

(1) * * *

* * * * * * *

(4) DEFINITIONS.—For purposes of this subsection:

(A) * * *

* * * * * * *

(C) ORIGINATING SITE.—

(i) * * *

(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

(I) * * *

* * * * * * *

(IX) A renal dialysis facility.

* * * * * * *

(F) TELEHEALTH SERVICE.—

(i) * * *

* * * * * * *

(iii) RECOMMENDATIONS OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.

(5) HOSPITAL CREDENTIALING OF TELEMEDICINE PRACTITIONERS.—A telemedicine practitioner that is credentialed by a hospital in compliance with the Joint Commission Standards for Telemedicine shall be considered in compliance with conditions of participation and reimbursement credentialing requirements under this title for telemedicine services.

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the [period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and] *period of 1 calendar year from which such services are furnished; and*

(2) a physician*, or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),* certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically

reviewed by a physician, [and] (iii) such services are or were furnished while the individual is or was under the care of a physician*, and (iv) in the case of a certification or recertification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification or recertification, or other reasonable timeframe as determined by the Secretary*;

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the

purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. *In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.*

* * * * * * *

ELIGIBLE INDIVIDUALS

SEC. 1836. [Every individual who] *(a) IN GENERAL.—Every individual who—*

(1) * * *

* * * * * * *

(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

(B) The individual shall be responsible for providing for payment of the portion of the premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

(C) The provision of such drugs shall be subject to the application of—

(i) the deductible under section 1833(b); and

(ii) the coinsurance amount applicable for such drugs (as determined under this part).

(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * * * *

(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to hospital insurance benefits under part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on

the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls or, at the option of the individual, on the first day of the second month following the last month of the individual's initial enrollment period.

(4) The Secretary of Defense shall establish a method for identifying individuals described in paragraph (1) and providing notice to them of their eligibility for enrollment during the special enrollment period described in paragraph (2).

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under [section 1837(i)(4)] *subsection (i)(4) or (l) of section 1837*, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iii)) or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Serv-

ices shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.

* * * * * * *

(i) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

(1) * * *

* * * * * * *

(4) MODIFIED ADJUSTED GROSS INCOME.—

(A) * * *

* * * * * * *

(C) USE OF MORE RECENT TAXABLE YEAR.—

(i) * * *

(ii) STANDARD FOR GRANTING REQUESTS.—A request under clause (i)(I) to use a more recent taxable year may be granted only if—

(I) * * *

(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, *sale of primary residence,* or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

* * * * * * *

PROVISIONS RELATING TO THE ADMINISTRATION OF PART B

SEC. 1842. (a) * * *

(b)

(2) * * *

* * * * * * *

(18)(A) * * *

* * * * * * *

(C) A practitioner described in this subparagraph is any of the following:

(i) * * *

* * * * * * *

(vii) A marriage and family therapist (as defined in section 1861(jjj)(2)).

(viii) A mental health counselor (as defined in section 1861(kkk)(2)).

* * * * * * *

(h)(1) * * *

* * * * * * *

(10) The Secretary may disenroll, for a period of not more than one year for each act, a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or

services written or ordered by such physician or supplier under this title, as specified by the Secretary.

* * * * * * *

(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to the following:

(A) In the case of any of the following drugs or biologicals, 95 percent of the average wholesale price:

(i) * * *

* * * * * * *

(iv) A vaccine described in [subparagraph (A) or (B) of] section 1861(s)(10) furnished on or after January 1, 2004 *and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011.*

* * * * * * *

USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

SEC. 1847A. (a) * * *

* * * * * * *

(c) MANUFACTURER'S AVERAGE SALES PRICE.—

(1) * * *

* * * * * * *

(6) DEFINITIONS AND OTHER RULES.—In this section:

(A) * * *

* * * * * * *

[(G) INCLUSION OF VACCINES.—In applying provisions of section 1927 under this section, "other than a vaccine" is deemed deleted from section 1927(k)(2)(B).]

(G) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) for purposes of implementation of this section.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

* * * * * * *

(4) SPECIAL RULE FOR IMAGING SERVICES.—

(A) * * *

(B) IMAGING SERVICES DESCRIBED.—For purposes of [subparagraph (A)] *this paragraph*, imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imag-

ing, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.

(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) , the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.

(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

* * * * * * *

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

* * * * * * *

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) * * *

(II) OPD PAYMENT CAP *AND OTHER PROVISIONS* FOR IMAGING SERVICES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

* * * * * * *

(K) POTENTIALLY MISVALUED CODES.—

(i) IN GENERAL.—The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be

appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called "Harvard-valued codes"); and such other codes determined to be appropriate by the Secretary.

(iii) REVIEW AND ADJUSTMENTS.—

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(L) VALIDATING RELATIVE VALUE UNITS.—

(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and pro-

fessional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre, post, and intra-service components of work.

(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii)

(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

* * * * * * *

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—

[The conversion factor**]** *(i) APPLICATION OF SINGLE CONVERSION FACTOR.—Subject to clause (ii), the conversion factor* for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved.

(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2011.—

(I) IN GENERAL.—In applying clause (i) for years beginning with 2011, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

(II) INITIAL CONVERSION FACTORS.—Such factors for 2011 shall be based upon the single conversion factor for the previous year multiplied by the update established under paragraph (11) for such category for 2011.

(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the

update established for such category under paragraph (11) for the year involved.

* * * * * * *

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for [other physicians' services] *for physicians' services described in the service category described in subsection (j)(5)(B)*, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) * * *

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable *or target* growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) * * *

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to [subparagraph (D)] *subparagraphs (D) and (G)* and the succeeding paragraphs of this subsection, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) * * *

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) * * *

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable *or target* growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

* * * * * * *

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) * * *

* * * * * * *

(iii) YEARS BEGINNING WITH 2000.—[The allowed] *Subject to paragraph (11)(B), the allowed* expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

* * * * * * *

(G) REBASING USING 2009 FOR FUTURE UPDATE ADJUSTMENTS.—In determining the update adjustment factor under subparagraph (B) for 2011 and subsequent years—

(i) the allowed expenditures for 2009 shall be equal to the amount of the actual expenditures for physicians' services during 2009; and

(ii) the reference in subparagraph (B)(ii)(I) to "April 1, 1996" shall be treated as a reference to "January 1, 2009 (or, if later, the first day of the fifth year before the year involved)".

* * * * * * *

(10) UPDATE FOR 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.

(11) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2011.—

(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2011, the following rules apply:

(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

(II) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2010, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

(i) FOR 2010.—For 2010:

(I) TOTAL 2009 ACTUAL EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION FOR EACH SERVICE CATEGORY.—Compute total actual expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2009 for each service category.

(II) INCREASE BY GROWTH RATE TO OBTAIN 2010 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2010 by increasing the allowed expendi-

tures for the service category for 2009 computed under subclause (I) by the target growth rate for such service category under subsection (f) for 2010.

(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) * * *

* * * * * * *

(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and [before January 1, 2010] *before January 1, 2012*, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

* * * * * * *

(6) TRANSITION TO USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

(A) IN GENERAL.—

(i) REVISION.—Subject to clause (ii) and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2011, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the Metropolitan Statistical Area (MSA) iterative Geographic Adjustment Factor methodology as follows:

(I) The Secretary shall configure the physician fee schedule areas using the Core-Based Statistical Areas-Metropolitan Statistical Areas (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget, as the basis for the fee schedule areas. The Secretary shall employ an iterative process to transition fee schedule areas. First, the Secretary shall list all MSAs within the State by Geographic Adjustment Factor described in paragraph (2) (in this paragraph referred to as a "GAF") in descending order. In the first iteration, the Secretary shall compare the GAF of the highest cost MSA in the State to the weighted-average GAF of the group of remaining MSAs in the State. If the ratio of the GAF of the highest cost MSA to the weighted-average GAF of the rest of State is 1.05 or greater then the highest cost MSA becomes a separate fee schedule area.

(II) In the next iteration, the Secretary shall compare the MSA of the second-highest GAF to the weighted-average GAF of the group of remaining MSAs. If the ratio of the second-highest MSA's

GAF to the weighted-average of the remaining lower cost MSAs is 1.05 or greater, the second-highest MSA becomes a separate fee schedule area. The iterative process continues until the ratio of the GAF of the highest-cost remaining MSA to the weighted-average of the remaining lower-cost MSAs is less than 1.05, and the remaining group of lower cost MSAs form a single fee schedule area, If two MSAs have identical GAFs, they shall be combined in the iterative comparison.

(ii) TRANSITION.—For services furnished on or after January 1, 2011, and before January 1, 2016, in the State of California, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply through application of this paragraph, the Secretary shall increase any such index to the county-based fee schedule area value on December 31, 2009, if such index would otherwise be less than the value on January 1, 2010.

(B) SUBSEQUENT REVISIONS.—

(i) PERIODIC REVIEW AND ADJUSTMENTS IN FEE SCHEDULE AREAS.—Subsequent to the process outlined in paragraph (1)(C), not less often than every three years, the Secretary shall review and update the California Rest-of-State fee schedule area using MSAs as defined by the Director of the Office of Management and Budget and the iterative methodology described in subparagraph (A)(i).

(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of the adjustment factors required under paragraph (1)(C) for California for 2012 and subsequent periods. Upon request, the Secretary shall make available to the public any county-level or MSA derived data used to calculate the geographic practice cost index.

(C) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2010, for the State of California, any reference in this section to a fee schedule area shall be deemed a reference to an MSA in the State.

(f) SUSTAINABLE GROWTH RATE *AND TARGET GROWTH RATE*.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; **[**and**]**

(B) November 1 of each succeeding year *before 2010* the sustainable growth rate for such succeeding year and each of the preceding 2 years**[**.**]***; and*

(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000)

and a year beginning with 2000 *and ending with 2009* shall be equal to the product of—

(A) * * *

* * * * * * *

(4) DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services ⟦(such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office⟧ *for which payment under this part is made under the fee schedule under this section, for services for practitioners described in section 1842(b)(18)(C) on a basis related to such fee schedule, or for services described in section 1861(p) (other than such services when furnished in the facility of a provider of services)*, but does not include services furnished to a Medicare+Choice plan enrollee.

* * * * * * *

(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2010.—The target growth rate for a year beginning with 2010 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the target growth rate except that the factor described in paragraph (2)(C) for—

(A) the service category described in subsection (j)(5)(A) shall be increased by 0.02; and

(B) the service category described in subsection (j)(5)(B) shall be increased by 0.01.

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

(2) FEE SCHEDULE AREA.—⟦The term⟧ *Except as provided in subsection (e)(6)(C), the term* "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), *(2)(FF),* (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

* * * * * * *

(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2009, each of the following categories of physicians' services (as defined in paragraph (3)) shall be treated as a separate "service category":

(A) Evaluation and management services that are procedure codes (for services covered under this title) for—

(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under subsection (c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

(ii) preventive services (as defined in section 1861(iii)) for which payment is made under this section.

(B) All other services not described in subparagraph (A). Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service.

(k) QUALITY REPORTING SYSTEM.—

(1) * * *

(2) USE OF CONSENSUS-BASED QUALITY MEASURES.—

(A) * * *

* * * * * * *

(C) FOR 2010 AND SUBSEQUENT YEARS.—

(i) * * *

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. *The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.*

* * * * * * *

(E) PHYSICIAN'S QUALITY REPORTING INITIATIVE.—

(i) IN GENERAL.—For purposes of reporting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to the extent that measures are available, the Secretary shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure both the creation of and adherence to orders for life-sustaining treatment.

(ii) PROPOSED SET OF MEASURES.—The Secretary shall publish in the Federal Register proposed quality measures on end of life care and advanced care planning that the Secretary determines are described in subparagraph (A) and would be appropriate for eligible professionals to use to submit data to the Secretary.

The Secretary shall provide for a period of public comment on such set of measures before finalizing such proposed measures.

* * * * * * *

(m) INCENTIVE PAYMENTS FOR QUALITY REPORTING.—

(1) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—For 2007 through [2010] *2012*, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) * * *

* * * * * * *

(B) APPLICABLE QUALITY PERCENT.—For purposes of subparagraph (A), the term "applicable quality percent" means—

(i) * * *

(ii) for [2009 and 2010] *for each of the years 2009 through 2012*, 2.0 percent.

* * * * * * *

(5) APPLICATION.—

(A) * * *

(B) COORDINATION WITH OTHER BONUS PAYMENTS.—The provisions of this subsection shall not be taken into account in applying subsections (m)*, (p),* and (u) of section 1833 and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

* * * * * * *

(E) LIMITATIONS ON REVIEW.—

[There shall be] *Subject to subparagraph (I), there shall be* no administrative or judicial review under 1869, section 1878, or otherwise of

(i) * * *

* * * * * * *

(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) INFORMAL APPEALS PROCESS.—Notwithstanding subparagraph (E), by not later than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to appeal the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

* * * * * * *

(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The development of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (o); and

(ii) clinical quality of care furnished to an individual.

(B) The collection of health data to identify deficiencies in the quality and coordination of care for individuals eligible for benefits under this part.

(C) Such other activities as specified by the Secretary.

* * * * * * *

(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) INCENTIVE PAYMENTS.—

(A) * * *

(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

(i) * * *

* * * * * * *

(iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.—In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a *primary care* health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

* * * * * * *

(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under the fee schedule under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(ii)) that result in the ordering of additional services (such as lab tests), the prescription of drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) * * *

* * * * * * *

(e) COVERAGE ELECTION PERIODS.—

(1) * * *

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) * * *

* * * * * * *

[(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

[(i) IN GENERAL.—Subject to clauses (ii) and (iii) and subparagraph (D), at any time during the first 3 months of a year after 2006, or, if the individual first becomes a Medicare+Choice eligible individual during a year after 2006, during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

[(ii) LIMITATION OF ONE CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

[(iii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE.—Effective for plan years beginning on or after January 1, 2006, in applying clause (i) (and clause (i) of subparagraph (B)) in the case of an individual who—

[(I) is enrolled in an MA plan that does provide qualified prescription drug coverage, the individual may exercise the right under such clause only with respect to coverage under the original fee-for-service plan or coverage under another MA plan that does not provide such coverage and may not exercise such right to obtain coverage under an MA–PD plan or under a prescription drug plan under part D; or

[(II) is enrolled in an MA–PD plan, the individual may exercise the right under such clause only with respect to coverage under another MA–PD plan (and not an MA plan that does not provide qualified prescription drug coverage) or under the original fee-for-service plan and coverage under a prescription drug plan under part D.]

* * * * * * *

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) * * *

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term "annual, coordinated election period" means—

(i) * * *

* * * * * * *

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006; [and]

(iv) with respect to 2007 [and succeeding years], *2008, 2009, and 2010*, the period beginning on November 15 and ending on December 31 of the year before such year[.]*; and*

(v) with respect to 2011 and succeeding years, the period beginning on November 1 and ending on December 15 of the year before such year.

* * * * * * *

(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A) * * *

* * * * * * *

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) * * *

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; [or]

(D) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or

[(D)] *(E)* the individual meets such other exceptional conditions as the Secretary may provide*, taking into account the health or well-being of the individual*.

* * * * * * *

(p) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

(1) IN GENERAL.—The Secretary shall publish, not later than November 1 of each year (beginning with 2011), for each MA plan contract, the medical loss ratio of the plan in the previous year.

(2) SUBMISSION OF DATA.—

(A) IN GENERAL.—Each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the medical loss ratio on a timely basis.

(B) DATA FOR 2010 AND 2011.—The data submitted under subparagraph (A) for 2010 and for 2011 shall be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010.

(C) USE OF STANDARDIZED ELEMENTS AND DEFINITIONS.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year, beginning with 2012, shall be submitted based on the standardized elements and definitions developed under paragraph (3).

(3) DEVELOPMENT OF DATA REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2012, of data necessary for the calculation of the medical loss ratio for MA plans. Not later than December 31, 2010, the Secretary shall publish a report describing the elements and definitions so developed.

(B) CONSULTATION.—The Secretary shall consult with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

(4) MEDICAL LOSS RATIO TO BE DEFINED.—For purposes of this part, the term "medical loss ratio" has the meaning given such term by the Secretary, taking into account the meaning given such term by the Health Choices Commissioner under section 116 of the America's Affordable Health Choices Act of 2009.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)) *with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option*.

(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

(i) IN GENERAL.—For purposes of this part, the term "benefits under the original medicare fee-for-service program option" means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B [or an actuarially equivalent level of cost-sharing as determined in this part].

[(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2), such expenses only with respect to subparagraph (A) of such section.]

(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed

as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.

* * * * * * *

[(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1859(b)(6)(B)(ii), the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan.]

(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Advantage plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) MONTHLY PAYMENTS.—

(A) * * *

* * * * * * *

(C) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—

(i) * * *

(ii) APPLICATION DURING PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—For 2006 [through 2010] *and each subsequent year*:

(I) * * *

(II) In order to ensure payment accuracy, the Secretary shall *periodically* conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated *on a timely basis* into the risk scores [only for 2008, 2009, and 2010] *for 2008 and subsequent years*. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available.

* * * * * * *

(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, *subject to subsection (o)*, the term "MA area-specific non-drug monthly benchmark amount" means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1860C–1(d)(2)(A), an amount equal to 1/12 of the annual MA capitation rate under section 1853(c)(1) (or, [beginning with 2007] *for 2007, 2008, 2009, and 2010*, 1/12 of the applicable amount determined under subsection (k)(1)*, or, beginning with 2011, 1/12 of the blended benchmark amount determined under subsection (n)(1)*) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

* * * * * * *

(n) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (3) and (4), the term "blended benchmark amount" means for an area—

(A) for 2011 the sum of—

(i) 2/3 of the applicable amount (as defined in subsection (k)) for the area and year; and

(ii) 1/3 of the amount specified in paragraph (2) for the area and year;

(B) for 2012 the sum of—

(i) 1/3 of the applicable amount for the area and year; and

(ii) 2/3 of the amount specified in paragraph (2) for the area and year; and

(C) for a subsequent year the amount specified in paragraph (2) for the area and year.

(2) SPECIFIED AMOUNT.—The amount specified in this paragraph for an area and year is the amount specified in subsection (c)(1)(D)(i) for the area and year adjusted (in a manner specified by the Secretary) to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4).

(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in paragraph (2).

(4) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

(o) QUALITY BASED PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—In the case of a qualifying plan in a qualifying county with respect to a year beginning with 2011, the blended benchmark amount under subsection (n)(1) shall be increased—

(A) for 2011, by 2.6 percent;

(B) for 2012, by 5.3 percent; and

(C) for a subsequent year, by 8.0 percent.

(2) QUALIFYING PLAN AND QUALIFYING COUNTY DEFINED.—For purposes of this subsection:

(A) QUALIFYING PLAN.—The term "qualifying plan" means, for a year and subject to paragraph (4), a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system estab-

lished by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

(B) QUALIFYING COUNTY.—The term "qualifying county" means, for a year, a county—

(i) that ranked within the lowest quartile of counties in the amount specified in subsection (n)(2) for the year specified by the Secretary under subparagraph (A); and

(ii) for which, as of June of such specified year, of the Medicare Advantage eligible individuals residing in the county—

(I) at least 50 percent of such individuals were enrolled in Medicare Advantage plans; and

(II) of the residents so enrolled at least 50 percent of such individuals were enrolled in such plans with a quality ranking (based on the quality ranking system established by the Centers for Medicare & Medicaid Services for Medicare Advantage plans) of 4 stars or higher.

(3) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) in 2010 and each succeeding year, shall notify the Medicare Advantage organization that is offering a qualifying plan in a qualifying county of such identification for the year. The Secretary shall provide for publication on the website for the Medicare program of the information described in the previous sentence.

(4) AUTHORITY TO DISQUALIFY DEFICIENT PLANS.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan's compliance with rules for Medicare Advantage plans under this part.

PREMIUMS AND BID AMOUNTS

SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS, BID AMOUNTS, AND RELATED INFORMATION.—

(1) * * *

* * * * * * *

(5) REVIEW.—

(A) * * *

* * * * * * *

(C) REJECTION OF BIDS.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid by an MA organization under this subsection.

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CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. (a) * * *

* * * * * * *

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs

under section 1858(c)), *and data submitted with respect to risk adjustment under section 1853(a)(3)* of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to *timely* inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to *timely* audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

* * * * * * *

(7) PERIOD FOR SUBMISSION OF CLAIMS.—The contract shall require an MA organization or PDP sponsor to require any provider of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrollee of such organization, written request, signed by such enrollee, except in cases in which the Secretary finds it impracticable for the enrollee to do so, is filed for payment for such items and services in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the 1 calendar year period after such items and services are furnished. In applying the previous sentence, the Secretary may specify exceptions to the 1 calendar year period specified.

(e) ADDITIONAL CONTRACT TERMS.—

(1) * * *

* * * * * * *

(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(p)(4)) of at least .85—

(A) the Secretary shall require the Medicare Advantage organization offering the plan to give enrollees a rebate (in the second succeeding contract year) of premiums under this part (or part B or part D, if applicable) by such amount as would provide for a benefits ratio of at least .85;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with an MA organization under this section shall include terms that inform the organization of the provisions in subsection (d).

(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.

(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

(1) * * *

* * * * * * *

(3) INCORPORATION OF CERTAIN PRESCRIPTION DRUG PLAN CONTRACT REQUIREMENTS.—The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D:

(A) * * *

[(B) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Section 1860D–12(b)(5).**]**

[(C)**]** *(B)* REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—Section 1860D–12(b)(6).

(C) REPORTING REQUIREMENT RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) * * *

* * * * * * *

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii); **[**or**]**

(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;

(I) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(J) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(K) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). *The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph.*

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, *except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,* plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

* * * * * * *

(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

(1) * * *

(2) EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans*, but only if 90 percent of the Medicare Advantage eligible individuals enrolled under such plan reside in a county in which the MA organization offers an MA local plan*. Notwithstanding section 1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

SPECIAL RULES FOR MA REGIONAL PLANS

SEC. 1858. (a) * * *

* * * * * * *

[(e) STABILIZATION FUND.—

[(1) ESTABLISHMENT.—The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the "Fund") which shall be available for two purposes:

[(A) PLAN ENTRY.—To provide incentives to have MA regional plans offered in each MA region under paragraph (3).

[(B) PLAN RETENTION.—To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).

[(2) FUNDING.—

[(A) INITIAL FUNDING.—

[(i) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund during 2014, $1.

[(ii) PAYMENT FROM TRUST FUNDS.—Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).

[(B) ADDITIONAL FUNDING FROM SAVINGS.—

[(i) IN GENERAL.—There shall also be made available to the Fund, 50 percent of savings described in clause (ii).

[(ii) SAVINGS.—The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.

[(iii) AVAILABILITY.—Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.

[(C) OBLIGATIONS.—Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).

[(D) ORDERING.—Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).

[(3) PLAN ENTRY FUNDING.—

[(A) IN GENERAL.—Funding is available under this paragraph for a year only as follows:

[(i) NATIONAL PLAN.—For a national bonus payment described in subparagraph (B) for the offering by a single MA organization of an MA regional plan in each MA region in the year, but only if there was not such a plan offered in each such region in the previous year. Funding under this clause is only available with respect to any individual MA organization for a single

year, but may be made available to more than one such organization in the same year.

[(ii) REGIONAL PLANS.—Subject to clause (iii), for an increased amount under subparagraph (C) for an MA regional plan offered in an MA region which did not have any MA regional plan offered in the prior year.

[(iii) LIMITATION ON REGIONAL PLAN FUNDING IN CASE OF NATIONAL PLAN.—In no case shall there be any payment adjustment under subparagraph (C) for a year for which a national payment adjustment is made under subparagraph (B).

[(B) NATIONAL BONUS PAYMENT.—The national bonus payment under this subparagraph shall—

[(i) be available to an MA organization only if the organization offers MA regional plans in every MA region;

[(ii) be available with respect to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

[(iii) subject to amounts available under paragraph (5) for a year, be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

[(C) REGIONAL PAYMENT ADJUSTMENT.—

[(i) IN GENERAL.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, based on the bid submitted for such plan (or plans) and shall be available to all MA regional plans offered in such region and year. Such amount may be based on the mean, mode, or median, or other measure of such bids and may vary from region to region. The Secretary may not limit the number of plans or bids in a region.

[(ii) MULTI-YEAR FUNDING.—

[(I) IN GENERAL.—Subject to amounts available under paragraph (5), funding under this subparagraph shall be available for a period determined by the Secretary.

[(II) REPORT.—If the Secretary determines that funding will be provided for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

[(iii) APPLICATION TO ALL PLANS IN A REGION.—Funding under this subparagraph with respect to an MA region shall be made available with respect to all MA regional plans offered in the region.

[(iv) LIMITATION ON AVAILABILITY OF PLAN RETENTION FUNDING IN NEXT YEAR.—If an increased amount is made available under this subparagraph with re-

spect to an MA region for a period determined by the Secretary under clause (ii)(I), in no case shall funding be available under paragraph (4) with respect to MA regional plans offered in the region in the year following such period.

[(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

[(4) PLAN RETENTION FUNDING.—

[(A) IN GENERAL.—Funding is available under this paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in subparagraph (B) but only if the region meets the requirements of subparagraphs (C) and (E).

[(B) PAYMENT INCREASE.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, that does not exceed the greater of—

[(i) 3 percent of the benchmark amount applicable in the region; or

[(ii) such amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

[(I) such additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) for the region and year, to the adjusted average per capita cost for the region and year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment; being equal to

[(II) the weighted average of such benchmark amounts for all the regions and such year, to the average per capita cost for the United States and such year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment.

[(C) REGIONAL REQUIREMENTS.—The requirements of this subparagraph for an MA region for a year are as follows:

[(i) NOTIFICATION OF PLAN EXIT.—The Secretary has received notice (in such form and manner as the Secretary specifies) before a year that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

[(ii) REGIONAL PLANS AVAILABLE FROM FEWER THAN 2 MA ORGANIZATIONS IN THE REGION.—The Secretary determines that if the plans referred to in clause (i) are not offered in the year, fewer than 2 MA organizations will be offering MA regional plans in the region in the year involved.

[(iii) PERCENTAGE ENROLLMENT IN MA REGIONAL PLANS BELOW NATIONAL AVERAGE.—For the previous

year, the Secretary determines that the average percentage of MA eligible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of such individuals in the United States enrolled in such plans.

[(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

[(E) 2-CONSECUTIVE-YEAR LIMITATION.—

[(i) IN GENERAL.—In no case shall any funding be available under this paragraph in an MA region in a period of consecutive years that exceeds 2 years.

[(ii) REPORT.—If the Secretary determines that funding will be provided under this paragraph for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

[(5) FUNDING LIMITATION.—

[(A) IN GENERAL.—The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.

[(B) APPLICATION OF LIMITATION.—The Secretary may obligate funds from the Fund for a year only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connection with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.

[(6) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2008), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

[(A) a detailed description of—

[(i) the total amount expended as a result of the application of this subsection in the previous year com-

pared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

[(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

[(iii) amounts remaining within the funding limitation specified in paragraph (5); and

[(iv) the steps that the Secretary will take under paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the amount available in the Fund; and

[(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the description provided under subparagraph (A) is reasonable, accurate, and based on generally accepted actuarial principles and methodologies.]

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DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) * * *

* * * * * * *

(f) REQUIREMENTS REGARDING ENROLLMENT IN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(1) REQUIREMENTS FOR ENROLLMENT.—In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before [January 1, 2011] *January 1, 2013 (or January 1, 2016, in the case of a plan described in section 1177(b)(1) of the America's Affordable Health Choices Act of 2009)*, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

* * * * * * *

(4) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) * * *

* * * * * * *

(C) The plan does not enroll an individual on or after January 1, 2011, other than during an annual, coordinated open enrollment period or when at the time of the diagnosis of the disease or condition that qualifies the individual as an individual described in subsection (b)(6)(B)(iii).

* * * * * * *

[COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM

[SEC. 1860C–1. (a) ESTABLISHMENT OF PROGRAM.—

[(1) IN GENERAL.—The Secretary shall establish a program under this section (in this section referred to as the "CCA program") for the application of comparative cost adjustment in CCA areas selected under this section.

[(2) DURATION.—The CCA program shall begin January 1, 2010, and shall extend over a period of 6 years, and end on December 31, 2015.

[(3) REPORT.—Upon the completion of the CCA program, the Secretary shall submit a report to Congress. Such report shall include the following, with respect to both this part and the original medicare fee-for-service program:

[(A) An evaluation of the financial impact of the CCA program.

[(B) An evaluation of changes in access to physicians and other health care providers.

[(C) Beneficiary satisfaction.

[(D) Recommendations regarding any extension or expansion of the CCA program.

[(b) REQUIREMENTS FOR SELECTION OF CCA AREAS.—

[(1) CCA AREA DEFINED.—

[(A) IN GENERAL.—For purposes of this section, the term "CCA area" means an MSA that meets the requirements of paragraph (2) and is selected by the Secretary under subsection (c).

[(B) MSA DEFINED.—For purposes of this section, the term "MSA" means a Metropolitan Statistical Area (or such similar area as the Secretary recognizes).

[(2) REQUIREMENTS FOR CCA AREAS.—The requirements of this paragraph for an MSA to be a CCA area are as follows:

[(A) MA ENROLLMENT REQUIREMENT.—For the reference month (as defined under section 1858(f)(4)(B)) with respect to 2010, at least 25 percent of the total number of MA eligible individuals who reside in the MSA were enrolled in an MA local plan described in section 1851(a)(2)(A)(i).

[(B) 2 PLAN REQUIREMENT.—There will be offered in the MSA during the annual, coordinated election period under section 1851(e)(3)(B) before the beginning of 2010 at least 2 MA local plans described in section 1851(a)(2)(A)(i) (in addition to the fee-for-service program under parts A and B), each offered by a different MA organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of the reference month.

[(c) SELECTION OF CCA AREAS.—

[(1) GENERAL SELECTION CRITERIA.—The Secretary shall select CCA areas from among those MSAs qualifying under subsection (b) in a manner that—

[(A) seeks to maximize the opportunity to test the application of comparative cost adjustment under this title;

[(B) does not seek to maximize the number of MA eligible individuals who reside in such areas; and

[(C) provides for geographic diversity consistent with the criteria specified in paragraph (2).

[(2) SELECTION CRITERIA.—With respect to the selection of MSAs that qualify to be CCA areas under subsection (b), the following rules apply, to the maximum extent feasible:

[(A) MAXIMUM NUMBER.—The number of such MSAs selected may not exceed the lesser of (i) 6, or (ii) 25 percent of the number of MSAs that meet the requirement of subsection (b)(2)(A).

[(B) ONE OF 4 LARGEST AREAS BY POPULATION.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the largest total population of MA eligible individuals.

[(C) ONE OF 4 AREAS WITH LOWEST POPULATION DENSITY.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the lowest population density (as measured by residents per square mile or similar measure of density).

[(D) MULTISTATE AREA.—At least one such qualifying MSA shall be selected that includes a multi-State area. Such an MSA may be an MSA described in subparagraph (B) or (C).

[(E) LIMITATION WITHIN SAME GEOGRAPHIC REGION.—No more than 2 such MSAs shall be selected that are, in whole or in part, within the same geographic region (as specified by the Secretary) of the United States.

[(F) PRIORITY TO AREAS NOT WITHIN CERTAIN DEMONSTRATION PROJECTS.—Priority shall be provided for those qualifying MSAs that do not have a demonstration project in effect as of the date of the enactment of this section for medicare preferred provider organization plans under this part.

[(d) APPLICATION OF COMPARATIVE COST ADJUSTMENT.—

[(1) IN GENERAL.—In the case of a CCA area for a year—

[(A) for purposes of applying this part with respect to payment for MA local plans, any reference to an MA area-specific non-drug monthly benchmark amount shall be treated as a reference to such benchmark computed as if the CCA area-specific non-drug monthly benchmark amount (as defined in subsection (e)(1)) were substituted for the amount described in section 1853(j)(1)(A) for the CCA area and year involved, as phased in under paragraph (3); and

[(B) with respect to months in the year for individuals residing in the CCA area who are not enrolled in an MA plan, the amount of the monthly premium under section 1839 is subject to adjustment under subsection (f).

[(2) EXCLUSION OF MA LOCAL AREAS WITH FEWER THAN 2 ORGANIZATIONS OFFERING MA PLANS.—

[(A) IN GENERAL.—In no case shall an MA local area that is within an MSA be included as part of a CCA area unless for 2010 (and, except as provided in subparagraph (B), for a subsequent year) there is offered in each part of such MA local area at least 2 MA local plans described in

section 1851(a)(2)(A)(i) each of which is offered by a different MA organization.

[(B) CONTINUATION.—If an MA local area meets the requirement of subparagraph (A) and is included in a CCA area for 2010, such local area shall continue to be included in such CCA area for a subsequent year notwithstanding that it no longer meets such requirement so long as there is at least one MA local plan described in section 1851(a)(2)(A)(i) that is offered in such local area.

[(3) PHASE-IN OF CCA BENCHMARK.—

[(A) IN GENERAL.—In applying this section for a year before 2013, paragraph (1)(A) shall be applied as if the phase-in fraction under subparagraph (B) of the CCA non-drug monthly benchmark amount for the year were substituted for such fraction of the MA area-specific non-drug monthly benchmark amount.

[(B) PHASE-IN FRACTION.—The phase-in fraction under this subparagraph is—

[(i) for 2010 ¼; and

[(ii) for a subsequent year is the phase-in fraction under this subparagraph for the previous year increased by ¼, but in no case more than 1.

[(e) COMPUTATION OF CCA BENCHMARK AMOUNT.—

[(1) CCA NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this section, the term "CCA non-drug monthly benchmark amount" means, with respect to a CCA area for a month in a year, the sum of the 2 components described in paragraph (2) for the area and year. The Secretary shall compute such benchmark amount for each such CCA area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which the CCA area is so selected.

[(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for a CCA area and a year are the following:

[(A) MA LOCAL COMPONENT.—The product of the following:

[(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (3)(A)).

[(ii) NON-FFS MARKET SHARE.—One minus the fee-for-service market share percentage, determined under paragraph (4) for the area and year.

[(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

[(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service area-specific non-drug amount (as defined in paragraph (5)) for the area and year.

[(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (4) for the area and year.

[(3) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A CCA AREA.—

[(A) IN GENERAL.—For purposes of paragraph (2)(A)(i), the weighted average of plan bids for a CCA area and a year is, subject to subparagraph (D), the sum of the following products for MA local plans described in subparagraph (C) in the area and year:

[(i) MONTHLY MEDICARE ADVANTAGE STATUTORY NON-DRUG BID AMOUNT.—The accepted unadjusted MA statutory non-drug monthly bid amount.

[(ii) PLAN'S SHARE OF MEDICARE ADVANTAGE ENROLLMENT IN AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all MA plans described in subparagraph (C) for that area and year.

[(B) COUNTING OF INDIVIDUALS.—The Secretary shall count, for each MA local plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during the reference month for that year.

[(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the MA local plans described in this subparagraph are MA local plans described in section 1851(a)(2)(A)(i) that are offered in the area and year and were offered in the CCA area in the reference month.

[(D) COMPUTATION OF WEIGHTED AVERAGE OF PLAN BIDS.—In calculating the weighted average of plan bids for a CCA area under subparagraph (A)—

[(i) in the case of an MA local plan that has a service area only part of which is within such CCA area, the MA organization offering such plan shall submit a separate bid for such plan for the portion within such CCA area; and

[(ii) the Secretary shall adjust such separate bid (or, in the case of an MA local plan that has a service area entirely within such CCA area, the plan bid) as may be necessary to take into account differences between the service area of such plan within the CCA area and the entire CCA area and the distribution of plan enrollees of all MA local plans offered within the CCA area.

[(4) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Secretary shall determine, for a year and a CCA area, the proportion (in this subsection referred to as the "fee-for-service market share percentage") equal to—

[(A) the total number of MA eligible individuals residing in such area who during the reference month for the year were not enrolled in any MA plan; divided by

[(B) the sum of such number and the total number of MA eligible individuals residing in such area who during such reference month were enrolled in an MA local plan described in section 1851(a)(2)(A)(i),

or, if greater, such proportion determined for individuals nationally.

[(5) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—

[(A) IN GENERAL.—For purposes of paragraph (2)(B)(i) and subsection (f)(2)(A), subject to subparagraph (C), the

term "fee-for-service area-specific non-drug amount" means, for a CCA area and a year, the adjusted average per capita cost for such area and year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment for benefits under the original medicare fee-for-service program option for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in an MA plan for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

[(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under section 1853(a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the CCA area.

[(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

[(f) PREMIUM ADJUSTMENT.—

[(1) APPLICATION.—

[(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of an individual who is enrolled under part B, who resides in a CCA area, and who is not enrolled in an MA plan under this part, the monthly premium otherwise applied under part B (determined without regard to subsections (b), (f), and (i) of section 1839 or any adjustment under this subsection) shall be adjusted in accordance with paragraph (2), but only in the case of premiums for months during the period in which the CCA program under this section for such area is in effect.

[(B) NO PREMIUM ADJUSTMENT FOR SUBSIDY ELIGIBLE BENEFICIARIES.—No premium adjustment shall be made under this subsection for a premium for a month if the individual is determined to be a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A)) for the month.

[(2) AMOUNT OF ADJUSTMENT.—

[(A) IN GENERAL.—Under this paragraph, subject to the exemption under paragraph (1)(B) and the limitation under subparagraph (B), if the fee-for-service area-specific non-drug amount (as defined in section (e)(5)) for a CCA area in which an individual resides for a month—

[(i) does not exceed the CCA non-drug monthly benchmark amount (as determined under subsection (e)(1)) for such area and month, the amount of the pre-

mium for the individual for the month shall be reduced, by an amount equal to 75 percent of the amount by which such CCA benchmark exceeds such fee-for-service area-specific non-drug amount; or

[(ii) exceeds such CCA non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure, that—

[(I) the sum of the amount of the adjusted premium and the CCA non-drug benchmark for the area; is equal to

[(II) the sum of the unadjusted premium plus the amount of such fee-for-service area-specific non-drug amount for the area.

[(B) LIMITATION.—In no case shall the actual amount of an adjustment under subparagraph (A) for an area and month in a year result in an adjustment that exceeds the maximum adjustment permitted under subparagraph (C) for the area and year, or, if less, the maximum annual adjustment permitted under subparagraph (D) for the area and year.

[(C) PHASE-IN OF ADJUSTMENT.—The amount of an adjustment under subparagraph (A) for a CCA area and year may not exceed the product of the phase-in fraction for the year under subsection (d)(3)(B) multiplied by the amount of the adjustment otherwise computed under subparagraph (A) for the area and year, determined without regard to this subparagraph and subparagraph (D).

[(D) 5-PERCENT LIMITATION ON ADJUSTMENT.—The amount of the adjustment under this subsection for months in a year shall not exceed 5 percent of the amount of the monthly premium amount determined for months in the year under section 1839 without regard to subsections (b), (f), and (i) of such section and this subsection.]

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

ELIGIBILITY, ENROLLMENT, AND INFORMATION

SEC. 1860D–1. (a) * * *

(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

(1) ESTABLISHMENT OF PROCESS.—

(A) * * *

* * * * * * *

(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D–14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such

plans in the PDP region *or through use of an intelligent assignment process that is designed to maximize the access of such individual to necessary prescription drugs while minimizing costs to such individual and to the program under this part to the greatest extent possible. In the case the Secretary enrolls such individuals through use of an intelligent assignment process, such process shall take into account the extent to which prescription drugs necessary for the individual are covered in the case of a PDP sponsor of a prescription drug plan that uses a formulary, the use of prior authorization or other restrictions on access to coverage of such prescription drugs by such a sponsor, and the overall quality of a prescription drug plan as measured by quality ratings established by the Secretary*. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(D) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an individual described in section 1860D–1(b)(3)(D) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment established under such section applicable to such individual, the application of the assignment process described in subparagraph (C) to such individual in the same manner as such assignment process applies to a part D eligible individual described in such subparagraph (C). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.

* * * * * * *

(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

(A) * * *

* * * * * * *

[(D) MEDICAID COVERAGE.—In the case of an individual (as determined by the Secretary) who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)).**]**

(D) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary) who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.

* * * * * * *

(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

(i) IN GENERAL.—Except as provided in clause (ii), in the case of an individual enrolled in a prescription drug plan (or MA–PD plan) who has been prescribed and is using a covered part D drug while so enrolled, if the formulary of the plan is materially changed (other than at the end of a contract year) so to reduce

the coverage (or increase the cost-sharing) of the drug under the plan.

(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration, because the drug is replaced with a generic drug that is a therapeutic equivalent, or because of utilization management applied to—

(I) a drug whose labeling includes a boxed warning required by the Food and Drug Administration under section 210.57(c)(1) of title 21, Code of Federal Regulations (or a successor regulation); or

(II) a drug required under subsection (c)(2) of section 505–1 of the Federal Food, Drug, and Cosmetic Act to have a Risk Evaluation and Management Strategy that includes elements under subsection (f) of such section.

* * * * * * *

PRESCRIPTION DRUG BENEFITS

SEC. 1860D–2. (a) * * *

(b) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term "standard prescription drug coverage" means coverage of covered part D drugs that meets the following requirements:

(1) * * *

* * * * * * *

(3) INITIAL COVERAGE LIMIT.—

(A) IN GENERAL.—Except as provided in [paragraph (4)] *paragraphs (4) and (7)*, the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

(i) * * *

* * * * * * *

(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

(A) * * *

(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

(i) IN GENERAL.—For purposes of this part *subject to paragraph (7)*, the "annual out-of-pocket threshold" specified in this subparagraph—

(I) * * *

* * * * * * *

(C) APPLICATION.—In applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered

part D drugs which are not included (or treated as being included) in the plan's formulary; [and]

(ii) [such costs shall be treated as incurred only if] *subject to subsection (g)(2)(C), subject to clause (iii), such costs shall be treated as incurred only if* they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual)[, under section 1860D–14, or under a State Pharmaceutical Assistance Program] and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs[.]*; and*

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

(I) under section 1860D–14;

(II) under a State Pharmaceutical Assistance Program;

(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.

* * * * * * *

(7) PHASED-IN ELIMINATION OF COVERAGE GAP.—

(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket threshold from the amounts otherwise computed until there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

(B) INCREASE IN INITIAL COVERAGE LIMIT.—For a year beginning with 2011, the initial coverage limit otherwise computed without regard to this paragraph shall be increased by ½ of the cumulative phase-in percentage (as defined in subparagraph (D)(ii) for the year) times the out-of-pocket gap amount (as defined in subparagraph (E)) for the year.

(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—For a year beginning with 2011, the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by ½ of the cumulative phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75.

(D) PHASE–IN.—For purposes of this paragraph:

(i) ANNUAL PHASE-IN PERCENTAGE.—The term "annual phase-in percentage" means—

(I) for 2011, 13 percent;

(II) for 2012, 2013, 2014, and 2015, 5 percent;

(III) for 2016 through 2018, 7.5 percent; and

(IV) for 2019 and each subsequent year, 10 percent.

(ii) CUMULATIVE PHASE-IN PERCENTAGE.—The term "cumulative phase-in percentage" means for a year the sum of the annual phase-in percentage for the year and the annual phase-in percentages for each previous year beginning with 2011, but in no case more than 100 percent.

(E) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term "out-of-pocket gap amount" means for a year the amount by which—

(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

(ii) the sum of—

(I) the annual deductible under paragraph (1) for the year; and

(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.

* * * * * * *

(e) COVERED PART D DRUG DEFINED.—

(1) IN GENERAL.—Except as provided in this subsection *and subsections (f) and (g)*, for purposes of this part, the term "covered part D drug" means—

(A) * * *

(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary),

and ❚such term includes a vaccine licensed under section 351 of the Public Health Service Act (and, for vaccines administered on or after January 1, 2008, its administration) and❚ any use of a covered part D drug for a medically accepted indication (as defined in paragraph (4)).

* * * * * * *

(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In this part, the term "covered part D drug" does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2010, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2010, to any full-benefit dual eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA organization under part C for such period. Such rebate shall be paid by the manufacturer to the Secretary not later

than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3).

(3) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer and dispensed to a full-benefit dual eligible individual, shall be equal to the product of—

(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period (as reported under section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3)); and

(ii) the amount (if any) by which—

(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

(II) the average Medicare drug program full-benefit dual eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term "Medicaid rebate amount" means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period—

(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(b) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

(C) AVERAGE MEDICARE DRUG PROGRAM FULL-BENEFIT DUAL ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term "average Medicare drug program full-benefit dual eligible rebate amount" means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

(i) the product, for each such sponsor or organization, of—

(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price con-

cession applies equally to drugs dispensed to full-benefit dual eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not full-benefit dual eligible individuals; and

(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA–PD organization; divided by

(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA–PD organizations.

(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

(A) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL.—The term "full-benefit dual eligible individual" has the meaning given such term in section 1935(c)(6).

(B) REBATE PERIOD.—The term "rebate period" has the meaning given such term in section 1927(k)(8).

(g) REQUIREMENT FOR MANUFACTURER DISCOUNT AGREEMENT FOR CERTAIN QUALIFYING DRUGS.—

(1) IN GENERAL.—In this part, the term "covered part D drug" does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect for all qualifying drugs (as defined in paragraph (5)(A)) a discount agreement described in paragraph (2).

(2) DISCOUNT AGREEMENT.—

(A) PERIODIC DISCOUNTS.—A discount agreement under this paragraph shall require the manufacturer involved to provide, to each PDP sponsor with respect to a prescription drug plan or each MA organization with respect to each MA–PD plan, a discount in an amount specified in paragraph (3) for qualifying drugs (as defined in paragraph (5)(A)) of the manufacturer dispensed to a qualifying enrollee after December 31, 2010, insofar as the individual is in the original gap in coverage (as defined in paragraph (5)(E)).

(B) DISCOUNT AGREEMENT.—Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement, including terms and conditions relating to compliance, similar to the terms and

conditions for rebate agreements under paragraphs (2), (3), and (4) of section 1927(b), except that—

(i) discounts shall be applied under this subsection to prescription drug plans and MA–PD plans instead of State plans under title XIX;

(ii) PDP sponsors and MA organizations shall be responsible, instead of States, for provision of necessary utilization information to drug manufacturers; and

(iii) sponsors and MA organizations shall be responsible for reporting information on drug-component negotiated price, instead of other manufacturer prices.

(C) COUNTING DISCOUNT TOWARD TRUE OUT-OF-POCKET COSTS.—Under the discount agreement, in applying subsection (b)(4), with regard to subparagraph (C)(i) of such subsection, if a qualified enrollee purchases the qualified drug insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the amount of the discount under the agreement shall be treated and counted as costs incurred by the plan enrollee.

(3) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price (as defined in paragraph (5)(C)) for qualifying drugs for the period involved.

(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

(A) insofar as the enrollee is in an actual gap of coverage (as defined in paragraph (5)(D)), the sponsor or plan shall provide the discount to the enrollee at the time the enrollee pays for the drug; and

(B) insofar as the enrollee is in the portion of the original gap in coverage (as defined in paragraph (5)(E)) that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price (as defined in subsection (d)(1)(B)) for the purpose of calculating the beneficiary payment.

(5) DEFINITIONS.—In this subsection:

(A) QUALIFYING DRUG.—The term "qualifying drug" means, with respect to a prescription drug plan or MA–PD plan, a drug or biological product that—

(i)(I) is a drug produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application;

(II) is a drug that was originally marketed under an original new drug application approved by the Food and Drug Administration; or

(III) is a biological product as approved under Section 351(a) of the Public Health Services Act;

(ii) is covered under the formulary of the plan; and

(iii) is dispensed to an individual who is in the original gap in coverage.

(B) QUALIFYING ENROLLEE.—The term "qualifying enrollee" means an individual enrolled in a prescription drug plan or MA–PD plan other than such an individual who is a subsidy-eligible individual (as defined in section 1860D–14(a)(3)).

(C) DRUG-COMPONENT NEGOTIATED PRICE.—The term "drug-component negotiated price" means, with respect to a qualifying drug, the negotiated price (as defined in subsection (d)(1)(B)), as determined without regard to any dispensing fee, of the drug under the prescription drug plan or MA–PD plan involved.

(D) ACTUAL GAP IN COVERAGE.—The term "actual gap in coverage" means the gap in prescription drug coverage that occurs between the initial coverage limit (as modified under subparagraph (B) of subsection (b)(7)) and the annual out-of-pocket threshold (as modified under subparagraph (C) of such subsection).

(E) ORIGINAL GAP IN COVERAGE.—The term "original in gap coverage" means the gap in prescription drug coverage that would occur between the initial coverage limit (described in subsection (b)(3)) and the out-of-pocket threshold (as defined in subsection (b)(4))(B) if subsection (b)(7) did not apply.

* * * * * * *

Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

PDP REGIONS; SUBMISSION OF BIDS; PLAN APPROVAL

SEC. 1860D–11. (a) * * *

* * * * * * *

(d) REVIEW OF INFORMATION AND NEGOTIATION.—

(1) * * *

* * * * * * *

(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids under this section in the same manner as it applies to bids by an MA organization under such section.

* * * * * * *

REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS

SEC. 1860D–12. (a) * * *

(b) CONTRACT REQUIREMENTS.—

(1) * * *

* * * * * * *

[(5) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that a pharmacy located in, or having a contract with,

a long-term care facility shall have not less than 30 days (but not more than 90 days) to submit claims to the sponsor for reimbursement under the plan.]

[(6)] *(5)* REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.—If the PDP sponsor of a prescription drug plan uses a standard for reimbursement of pharmacies based on the cost of a drug, each contract entered into with such sponsor under this part with respect to the plan shall provide that the sponsor shall update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.

(6) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

(B) REPORT FORM AND CONTENTS.—Not later than 60 days after the end of each rebate period (as defined in section 1860D–2(f)(6)(B)) within such a contract year to which such section applies, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to full-benefit dual eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to full-benefit dual eligible Medicare drug plan enrollees and PDP enrollees who are not full-benefit dual eligible Medicare drug plan enrollees; and

(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program full-benefit dual eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

(i) that any reference to "this section" in clause (i) of such subparagraph shall be treated as being a reference to this section;

(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

(iii) clause (iv) of such subparagraph shall not apply.

(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

SEC. 1860D–14. (a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LINE.—

(1) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) *(or, beginning with 2012, paragraph (3)(E))* or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

(A) * * *

* * * * * * *

(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—

(i) [INSTITUTIONALIZED INDIVIDUALS.—In] *ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—*

(I) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1902(q)(1)(B)), the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).

(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1932, or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).

* * * * * * *

(3) DETERMINATION OF ELIGIBILITY.—

(A) * * *

* * * * * * *

(E) ALTERNATIVE RESOURCE STANDARD.—

(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program subject to the life insurance policy exclusion provided under subparagraph (G)) do not exceed—

(I) for 2006, $10,000 (or $20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); [and]

(II) for a subsequent year *(before 2012)* the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year[.]*;*

(III) for 2012, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any dollar amount established under subclause (II) *or (IV)* that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

* * * * * * *

[(iii) DOCUMENTATION AND SAFEGUARDS.—Under such process—

[(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

[(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

[(III) matters attested to in the application shall be subject to appropriate methods of verification.]

(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.

* * * * * * *

(b) PREMIUM SUBSIDY AMOUNT.—

(1) * * *

(2) LOW-INCOME BENCHMARK PREMIUM AMOUNT DEFINED.—

(A) * * *

(B) PREMIUM AMOUNTS DESCRIBED.—The premium amounts described in this subparagraph are, in the case of—

(i) * * *

* * * * * * *

(iii) an MA–PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)) *before the application of the*

monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year involved.

* * * * * * *

MEDICARE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1860D–16. (a) * * *

* * * * * * *

(c) DEPOSITS INTO ACCOUNT.—

(1) * * *

* * * * * * *

(6) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

(a) * * *

* * * * * * *

(s) MEDICAL AND OTHER HEALTH SERVICES.—The term "medical and other health services" means any of the following items or services:

(1) * * *

(2)(A) * * *

* * * * * * *

(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined in subsection (eee)(4)); [and]

(EE) kidney disease education services (as defined in subsection (ggg));

(FF) advance care planning consultation (as defined in subsection (hhh)(1));

(GG) marriage and family therapist services (as defined in subsection (jjj)); and

(HH) mental health counselor services (as defined in subsection (kkk)(1));

* * * * * * *

[(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration; and

[(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);]

(10) federally recommended vaccines (as defined in subsection (lll)) and their respective administration;

* * * * * * *

(aa) RURAL HEALTH CLINIC SERVICES AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—(1) The term "rural health clinic services" means —

(A) * * *

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) [or by a clinical social worker (as defined in subsection (hh)(1)),], *by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (jjj)(2)), or a mental health counselor (as defined in subsection (kkk)(2)),* and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

* * * * * * *

(3) The term "Federally qualified health center services" means—

[(A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and services described in subsections (qq) and (vv); and]

(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and services described in section 1861(iii); and

* * * * * * *

(hh) CLINICAL SOCIAL WORKER; CLINICAL SOCIAL WORKER SERVICES.—(1) * * *

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital [and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation]) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

* * * * * * *

(ww) INITIAL PREVENTIVE PHYSICAL EXAMINATION.—(1) * * *

(2) The screening and other preventive services described in this paragraph include the following:

(A) [Pneumococcal, influenza, and hepatitis B vaccine and administration] *Federally recommended vaccines (as defined in subsection (lll)) and their respective administration* under subsection (s)(10).

* * * * * * *

Advance Care Planning Consultation

(hhh)(1) Subject to paragraphs (3) and (4), the term "advance care planning consultation" means a consultation between the individual

and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act of 1965).

(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

(ii) The Secretary shall limit the requirement for explanations under clause (i) to consultations furnished in a State—

(I) in which all legal barriers have been addressed for enabling orders for life sustaining treatment to constitute a set of medical orders respected across all care settings; and

(II) that has in effect a program for orders for life sustaining treatment described in clause (iii).

(iii) A program for orders for life sustaining treatment for a States described in this clause is a program that—

(I) ensures such orders are standardized and uniquely identifiable throughout the State;

(II) distributes or makes accessible such orders to physicians and other health professionals that (acting within the

scope of the professional's authority under State law) may sign orders for life sustaining treatment;

(III) provides training for health care professionals across the continuum of care about the goals and use of orders for life sustaining treatment; and

(IV) is guided by a coalition of stakeholders includes representatives from emergency medical services, emergency department physicians or nurses, state long-term care association, state medical association, state surveyors, agency responsible for senior services, state department of health, state hospital association, home health association, state bar association, and state hospice association.

(2) A practitioner described in this paragraph is—

(A) a physician (as defined in subsection (r)(1)); and

(B) a nurse practitioner or physician assistant who has the authority under State law to sign orders for life sustaining treatments.

(3)(A) An initial preventive physical examination under subsection (WW), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

(B) An advance care planning consultation with respect to an individual may be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

(5)(A) For purposes of this section, the term "order regarding life sustaining treatment" means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order, including a nurse practitioner or physician assistant) and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care;

(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and

(iv) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to

limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

(i) the intensity of medical intervention if the patient is pulse less, apneic, or has serious cardiac or pulmonary problems;

(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

(iii) the use of antibiotics; and

(iv) the use of artificially administered nutrition and hydration.

Medicare Covered Preventive Services

(iii)(1) Subject to the succeeding provisions of this subsection, the term "Medicare covered preventive services" means the following:

(A) Prostate cancer screening tests (as defined in subsection (oo)).

(B) Colorectal cancer screening tests (as defined in subsection (pp).

(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

(F) An initial preventive physical examination (as defined in subsection (ww)).

(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

(H) Diabetes screening tests (as defined in subsection (yy)).

(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

(J) Federally recommended vaccines (as defined in subsection (lll)) and their respective administration.

(K) Screening mammography (as defined in subsection (jj)).

(L) Screening pap smear and screening pelvic exam (as defined in subsection (nn)).

(M) Bone mass measurement (as defined in subsection (rr)).

(N) Kidney disease education services (as defined in subsection (ggg)).

(O) Additional preventive services (as defined in subsection (ddd)).

(2) With respect to specific Medicare covered preventive services, the limitations and conditions described in the provisions referenced in paragraph (1) with respect to such services shall apply.

Marriage and Family Therapist Services

(jjj)(1) The term "marriage and family therapist services" means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no fa-

cility or other provider charges or is paid any amounts with respect to the furnishing of such services.

(2) The term "marriage and family therapist" means an individual who—

(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.

Mental Health Counselor Services

(kkk)(1) The term "mental health counselor services" means services performed by a mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

(2) The term "mental health counselor" means an individual who—

(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

Federally Recommended Vaccines

(lll) The term "federally recommended vaccine" means an approved vaccine recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1861(s)(2)(AA), [and]

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1861(ggg)), which are furnished in excess of the number of sessions covered under paragraph (4) of such section[;], *and*

(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;

* * * * * * *

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (B), (F), (G), (H), [or (K)] *(K), or (P)* of paragraph (1));

* * * * * * *

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

* * * * * * *

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) * * *

* * * * * * *

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before the date of enactment of the Balanced Budget Act of 1997 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18- month" for "12-month" each place it appears. Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears. *With regard to immunosuppressive drugs furnished on or after the date of the enactment of the America's Affordable Health Choices Act of 2009, this subparagraph shall be applied without regard to any time limitation.*

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be

qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) * * *

* * * * * * *

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services, **[**and**]**

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)**[**.**]***; and*

* * * * * * *

(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (*other than for Medicare covered preventive services and* not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment

under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

* * * * * * *

(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) * * *

* * * * * * *

(D) BILLING AGENTS AND CLEARINGHOUSES REQUIRED TO BE REGISTERED UNDER MEDICARE.—Any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must be registered with the Secretary in a form and manner specified by the Secretary.

* * * * * * *

(3) PROGRAM INTEGRITY.—The provisions of section 1128G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.

* * * * * * *

HEALTH CARE QUALITY DEMONSTRATION PROGRAM

SEC. 1866C. (a) * * *

(b) DEMONSTRATION PROJECTS.—[The Secretary] *Subject to section 1866D, the Secretary* shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

(1) * * *

* * * * * * *

CONVERSION OF ACUTE CARE EPISODE DEMONSTRATION TO PILOT PROGRAM AND EXPANSION TO INCLUDE POST ACUTE SERVICES

SEC. 1866D. (a) CONVERSION AND EXPANSION.—

(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient and high quality delivery of care—

(A) convert the acute care episode demonstration program conducted under section 1866C to a pilot program; and

(B) subject to subsection (c), expand such program as so converted to include post acute services and such other

services the Secretary determines to be appropriate, which may include transitional services.

(2) BUNDLED PAYMENT STRUCTURES.—

(A) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

(i) hospitals and physicians;

(ii) hospitals and post-acute care providers;

(iii) hospitals, physicians, and post-acute care providers; or

(iv) combinations of post-acute providers.

(B) FURTHER APPLICATION.—

(i) IN GENERAL.—In carrying out paragraph (1), the Secretary shall apply bundled payments in a manner so as to include collaborative care networks and continuing care hospitals.

(ii) COLLABORATIVE CARE NETWORK DEFINED.—For purposes of this subparagraph, the term "collaborative care network" means a consortium of health care providers that provides a comprehensive range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality and efficiency of care, increase preventive services, and promote adherence to post-acute and follow-up care plans.

(iii) CONTINUING CARE HOSPITAL DEFINED.—For purposes of this subparagraph, the term "continuing care hospital" means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long-term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).

(b) SCOPE.—The pilot program under subsection (a) may include additional geographic areas and additional conditions which account for significant program spending, as defined by the Secretary. Nothing in this subsection shall be construed as limiting the number of hospital and physician groups or the number of hospital and post-acute provider groups that may participate in the pilot program.

(c) LIMITATION.—The Secretary shall only expand the pilot program under subsection (a) if the Secretary finds that—

(1) the demonstration program under section 1866C and pilot program under this section maintain or increase the quality of care received by individuals enrolled under this title; and

(2) such demonstration program and pilot program reduce program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

(d) CERTIFICATION.—For purposes of subsection (c), the Chief Actuary of the Centers for Medicare & Medicaid Services shall certify whether expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.

(f) EVALUATION ON COST AND QUALITY OF CARE.—The Secretary shall conduct an evaluation of the pilot program under subsection (a) to study the effect of such program on costs and quality of care. The findings of such evaluation shall be included in the final report required under section 1152(e)(2) of America's Affordable Health Choices Act of 2009.

(g) STUDY OF ADDITIONAL BUNDLING AND EPISODE-BASED PAYMENT FOR PHYSICIANS' SERVICES.—

(1) IN GENERAL.—The Secretary shall provide for a study of and development of a plan for testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital services or services rendered in physicians' offices, other than those provided under the pilot program.

(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.

ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

SEC. 1866E. (a) IN GENERAL.—The Secretary shall conduct a pilot program (in this section referred to as the "pilot program") to test different payment incentive models, including (to the extent practicable) the specific payment incentive models described in subsection (c), designed to reduce the growth of expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)) by qualifying accountable care organizations (as defined in subsection (b)(1)) in order to—

(1) promote accountability for a patient population and coordinate items and services under parts A and B;

(2) encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and

(3) reward physician practices and other physician organizational models for the provision of high quality and efficient health care services.

(b) QUALIFYING ACCOUNTABLE CARE ORGANIZATIONS (ACOS).—

(1) QUALIFYING ACO DEFINED.—In this section:

(A) IN GENERAL.—The terms "qualifying accountable care organization" and "qualifying ACO" mean a group of physicians or other physician organizational model (as defined in subparagraph (D)) that—

(i) is organized at least in part for the purpose of providing physicians' services; and

(ii) meets such criteria as the Secretary determines to be appropriate to participate in the pilot program, including the criteria specified in paragraph (2).

(B) INCLUSION OF OTHER PROVIDERS.—Nothing in this subsection shall be construed as preventing a qualifying ACO from including a hospital or any other provider of services or supplier furnishing items or services for which payment may be made under this title that is affiliated with the ACO under an arrangement structured so that such provider or supplier participates in the pilot program and shares in any incentive payments under the pilot program.

(C) PHYSICIAN.—The term "physician" includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services.

(D) OTHER PHYSICIAN ORGANIZATIONAL MODEL.—The term "other physician organization model" means, with respect to a qualifying ACO any model of organization under which physicians enter into agreements with other providers for the purposes of participation in the pilot program in order to provide high quality and efficient health care services and share in any incentive payments under such program

(E) OTHER SERVICES.—Nothing in this paragraph shall be construed as preventing a qualifying ACO from furnishing items or services, for which payment may not be made under this title, for purposes of achieving performance goals under the pilot program.

(2) QUALIFYING CRITERIA.—The following are criteria described in this paragraph for an organized group of physicians to be a qualifying ACO:

(A) The group has a legal structure that would allow the group to receive and distribute incentive payments under this section.

(B) The group includes a sufficient number of primary care physicians (regardless of specialty) for the applicable beneficiaries for whose care the group is accountable (as determined by the Secretary).

(C) The group reports on quality measures in such form, manner, and frequency as specified by the Secretary (which may be for the group, for providers of services and suppliers, or both).

(D) The group reports to the Secretary (in a form, manner and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the pilot program.

(E) The group provides notice to applicable beneficiaries regarding the pilot program (as determined appropriate by the Secretary).

(F) The group contributes to a best practices network or website, that shall be maintained by the Secretary for the purpose of sharing strategies on quality improvement, care coordination, and efficiency that the groups believe are effective.

(G) The group utilizes patient-centered processes of care, including those that emphasize patient and caregiver in-

volvement in planning and monitoring of ongoing care management plan.

(H) The group meets other criteria determined to be appropriate by the Secretary.

(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The specific payment incentive models described in this subsection are the following:

(1) PERFORMANCE TARGET MODEL.—Under the performance target model under this paragraph (in this paragraph referred to as the "performance target model"):

(A) IN GENERAL.—A qualifying ACO qualifies to receive an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment shall be made only if savings are greater than would result from normal variation in expenditures for items and services covered under parts A and B.

(B) COMPUTATION OF PERFORMANCE TARGET.—

(i) IN GENERAL.—The Secretary shall establish a performance target for each qualifying ACO comprised of a base amount (described in clause (ii)) increased to the current year by an adjustment factor (described in clause (iii)). Such a target may be established on a per capita basis, as the Secretary determines to be appropriate.

(ii) BASE AMOUNT.—For purposes of clause (i), the base amount in this subparagraph is equal to the average total payments (or allowed charges) under parts A and B (and may include part D, if the Secretary determines appropriate) for applicable beneficiaries for whom the qualifying ACO furnishes items and services in a base period determined by the Secretary. Such base amount may be determined on a per capita basis.

(iii) ADJUSTMENT FACTOR.—For purposes of clause (i), the adjustment factor in this clause may equal an annual per capita amount that reflects changes in expenditures from the period of the base amount to the current year that would represent an appropriate performance target for applicable beneficiaries (as determined by the Secretary). Such adjustment factor may be determined as an amount or rate, may be determined on a national, regional, local, or organization-specific basis, and may be determined on a per capita basis. Such adjustment factor also may be adjusted for risk as determined appropriate by the Secretary.

(iv) REBASING.—Under this model the Secretary shall periodically rebase the base expenditure amount described in clause (ii).

(C) MEETING TARGET.—

(i) IN GENERAL.—Subject to clause (ii), a qualifying ACO that meet or exceeds annual quality and performance targets for a year shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount by which payments under this title for such year relative are estimated to be below the performance target for such year,

as determined by the Secretary. The Secretary may establish a cap on incentive payments for a year for a qualifying ACO.

(ii) LIMITATION.— The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title (inclusive of incentive payments described in this subparagraph) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program under this section were not implemented.

(D) REPORTING AND OTHER REQUIREMENTS.—In carrying out such model, the Secretary may (as the Secretary determines to be appropriate) incorporate reporting requirements, incentive payments, and penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in this subparagraph shall not be included in the limit described in subparagraph (C)(ii) or in the performance target model described in this paragraph.

(2) PARTIAL CAPITATION MODEL.—

(A) IN GENERAL.—Subject to subparagraph (B), a partial capitation model described in this paragraph (in this paragraph referred to as a "partial capitation model") is a model in which a qualifying ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to a qualifying ACO for applicable beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(3) OTHER PAYMENT MODELS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(d) APPLICABLE BENEFICIARIES.—

(1) IN GENERAL.—In this section, the term "applicable beneficiary" means, with respect to a qualifying ACO, an individual who—

(A) is enrolled under part B and entitled to benefits under part A;

(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

(C) meets such other criteria as the Secretary determines appropriate, which may include criteria relating to frequency of contact with physicians in the ACO

(2) FOLLOWING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying ACO.

(e) IMPLEMENTATION.—

(1) STARTING DATE.—The pilot program shall begin no later than January 1, 2012. An agreement with a qualifying ACO under the pilot program may cover a multi-year period of between 3 and 5 years.

(2) WAIVER.—The Secretary may waive such provisions of this title (including section 1877) and title XI in the manner the Secretary determines necessary in order implement the pilot program.

(3) PERFORMANCE RESULTS REPORTS.—The Secretary shall report performance results to qualifying ACOs under the pilot program at least annually.

(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) the elements, parameters, scope, and duration of the pilot program;

(B) the selection of qualifying ACOs for the pilot program;

(C) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the amount of savings;

(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(E) decisions about the extension of the program under subsection (g), expansion of the program under subsection (h) or extensions under subsection (i).

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(f) EVALUATION; MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate the payment incentive model for each qualifying ACO under the pilot program to assess impacts on beneficiaries, providers of services, suppliers and the program under this title. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

(2) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of ACOs under the pilot program with regard to violations of section 1877 (popularly known as the "Stark law").

(g) EXTENSION OF PILOT AGREEMENT WITH SUCCESSFUL ORGANIZATIONS.—

(1) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and biennially thereafter for six years, the Secretary shall submit to Congress and make publicly available a report on the use of authorities under the pilot program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under this title.

(2) EXTENSION.—Subject to the report provided under paragraph (1), with respect to a qualifying ACO, the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate if—

(A) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or

(B) the ACO is consistently exceeding quality standards and is not increasing spending under the program.

(3) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.

(h) EXPANSION TO ADDITIONAL ACOS.—

(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE MODELS.—Subject to the evaluation described in subsection (f), the Secretary may enter into agreements under the pilot program with additional qualifying ACOs to further test and refine payment incentive models with respect to qualifying ACOs.

(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, 1 or more models if, and to the extent that, such models are beneficial to the program under this title, as determined by the Secretary.

(B) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall certify that 1 or more of such models described in subparagraph (A) would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.

(i) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—

(1) EXTENSION.—The Secretary may enter in to an agreement with a qualifying ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary, until the pilot program under this section is operational.

(2) TRANSITION.—For purposes of extension of an agreement with a qualifying ACO under subsection (g)(2), the Secretary shall treat receipt of an incentive payment for a year by an organization under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such subsection, as long as such practice

group practice organization meets the criteria under subsection (b)(2).

(j) ADDITIONAL PROVISIONS.—

(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect natural variations in data availability, variation in average annual attributable expenditures, program integrity, and other matters the Secretary deems appropriate.

(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organizations under the pilot program, the Secretary may limit a qualifying ACO's exposure to high cost patients under the program.

(3) INVOLVEMENT IN PRIVATE PAYER ARRANGEMENTS.—Nothing in this section shall be construed as preventing qualifying ACOs participating in the pilot program from negotiating similar contracts with private payers.

(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

(5) CONSTRUCTION.—Nothing in this section shall be construed to compel or require an organization to use an organization-specific target growth rate for an accountable care organization under this section for purposes of section 1848.

(6) FUNDING.—For purposes of administering and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c)(1), in addition to funds otherwise appropriated, there are appropriated to the Secretary for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of fiscal years 2010 through 2014 and $20,000,000 for fiscal year 2015. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

MEDICAL HOME PILOT PROGRAM

SEC. 1866F. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the "pilot program") for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to high need beneficiaries (as defined in subsection (d)(1)(C)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

(2) SCOPE.—Subject to subsection (g), the pilot program shall include urban, rural, and underserved areas.

(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

(i) all the requirements of this section are met; and

(ii) the nurse practitioner is acting consistently with State law.

(B) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

(i) all the requirements of this section are met; and

(ii) the physician assistant is acting consistently with State law.

(b) DEFINITIONS.—For purposes of this section:

(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term "patient-centered medical home services" means services that—

(A) provide beneficiaries with direct and ongoing access to a primary care or principal care by a physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

(C) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified providers for all stages of life;

(D) provide continuous access to care and communication with participating beneficiaries;

(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

(2) PRIMARY CARE.—The term "primary care" means health care that is provided by a physician, nurse practitioner, or phy-

sician assistant who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

(3) PRINCIPAL CARE.—The term "principal care" means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management.

(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

(1) IN GENERAL.—

(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3)(B) for a targeted high need beneficiaries (as defined in subparagraph (C)).

(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term "independent patient-centered medical home" means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

(i) providing beneficiaries with patient-centered medical home services; and

(ii) meets such other requirements as the Secretary may specify.

(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term "targeted high need beneficiary" means a high need beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 6 months after the date of the enactment of this section.

(2) STANDARD SETTING AND QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall review alternative models for standard setting and qualification, and shall establish a process—

(A) to establish standards to enable medical practices to qualify as patient-centered medical homes; and

(B) to initially provide for the review and certification of medical practices as meeting such standards.

(3) PAYMENT.—

(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

(i) The clinical work and practice expenses involved in providing the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers.

(5) NO DUPLICATION IN PILOT PARTICIPATION.—A physician in a group practice that participates in the accountable care organization pilot program under section 1866D shall not be eligible to participate in the pilot program under this subsection, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

(1) IN GENERAL.—

(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the "CBMH model"), the Secretary shall make payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for high need beneficiaries.

(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term "community-based medical home" means a nonprofit community-based or State-based organization that is certified under paragraph (2) as meeting the following requirements:

(i) The organization provides beneficiaries with medical home services.

(ii) The organization provides medical home services under the supervision of and in close collaboration

with the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary as his or her community-based medical home provider.

(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

(iv) The organization meets such other requirements as the Secretary may specify.

(C) HIGH NEED BENEFICIARY.—In this section, the term "high need beneficiary" means an individual who requires regular medical monitoring, advising, or treatment.

(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process—

(A) for the initial qualification of community-based or State-based organizations as community-based medical homes; and

(B) to provide for the review and qualification of such community-based and State-based organizations pursuant to criteria established by the Secretary.

(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under subsection (i).

(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary may give preference to—

(A) applications from geographic areas that propose to coordinate health care services for chronically ill beneficiaries across a variety of health care settings, such as primary care physician practices with fewer than 10 physicians, specialty physicians, nurse practitioner practices, Federally qualified health centers, rural health clinics, and other settings;

(B) applications that include other payors that furnish medical home services for chronically ill patients covered by such payors; and

(C) applications from States that propose to use the medical home model to coordinate health care services for individuals enrolled under this title, individuals enrolled under title XIX, and full-benefit dual eligible individuals (as defined in section 1935(c)(6)) with chronic diseases across a variety of health care settings.

(5) PAYMENTS.—

(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each high need beneficiary who consents to receive medical home services through such medical home, as follows:

(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization.

(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

(D) AMOUNT OF PAYMENT.—In determining the amount of such payment, the Secretary shall consider the following:

(i) The clinical work and practice expenses involved in providing the medical home services provided by the community-based medical home (such as providing increased access, care coordination, care plan setting, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a community based or State-based organization or a State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes how such funds will be used.

(e) EXPANSION OF PROGRAM.—

(1) EVALUATION OF COST AND QUALITY.—The Secretary shall evaluate the pilot program to determine—

(A) the extent to which medical homes result in—

(i) improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;

(ii) improvement in reducing health disparities;

(iii) reductions in preventable hospitalizations;

(iv) prevention of readmissions;

(v) reductions in emergency room visits;

(vi) improvement in health outcomes, including patient functional status where applicable;

(vii) improvement in patient satisfaction;

(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

(ix) reductions in health care expenditures; and

(B) the feasability and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(3) EXPANSION OF PROGRAM.—

(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

(f) ADMINISTRATIVE PROVISIONS.—

(1) NO DUPLICATION IN PAYMENTS.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

(2) NO EFFECT ON PAYMENT FOR EVALUATION AND MANAGEMENT SERVICES.—Payments made under this section are in addition to, and have no effect on the amount of, payment for evaluation and management services made under this title

(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

(g) FUNDING.—

(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

(B) $125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount provided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note).

(2) Notwithstanding section 1302(c) of the America's Affordable Health Choices Act of 2009, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).

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PRACTICING PHYSICIANS ADVISORY COUNCIL; COUNCIL FOR TECHNOLOGY AND INNOVATION *TELEHEALTH ADVISORY COMMITTEE*

SEC. 1868. ⟦(a) PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1) The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this subsection referred to as the "Council") to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

⟦(2) The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

⟦(3) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title.⟧

* * * * * * *

(c) TELEHEALTH ADVISORY COMMITTEE.—

(1) IN GENERAL.—The Secretary shall appoint a Telehealth Advisory Committee (in this subsection referred to as the "Advisory Committee") to make recommendations to the Secretary on policies of the Centers for Medicare & Medicaid Services re-

garding telehealth services as established under section 1834(m), including the appropriate addition or deletion of services (and HCPCS codes) to those specified in paragraphs (4)(F)(i) and (4)(F)(ii) of such section and for authorized payment under paragraph (1) of such section.

(2) MEMBERSHIP; TERMS.—

(A) MEMBERSHIP.—

(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

(I) 5 shall be practicing physicians;

(II) 2 shall be practicing non-physician health care practitioners; and

(III) 2 shall be administrators of telehealth programs.

(ii) REQUIREMENTS FOR APPOINTING MEMBERS.—In appointing members of the Advisory Committee, the Secretary shall—

(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

(IV) take into account the recommendations of stakeholders.

(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.

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ADMINISTRATION

SEC. 1874. (a) * * *

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(e) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) IN GENERAL.—The Secretary may disenroll a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title (or may impose any civil monetary penalty or other intermediate sanction under paragraph (4)) if

such provider of services or supplier fails to, subject to paragraph (5), establish a compliance program that contains the core elements established under paragraph (2).

(2) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under paragraph (1). Such elements may include written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse for the organization's employees and contractors; a confidential or anonymous mechanism, such as a hotline, to receive compliance questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.

(3) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under paragraph (2) and the date on which a provider of services and suppliers (other than physicians) shall be required to have established such a program for purposes of this subsection.

(4) CMS ENFORCEMENT AUTHORITY.—The Administrator for the Centers of Medicare & Medicaid Services shall have the authority to determine whether a provider of services or supplier described in subparagraph (3) has met the requirement of this subsection and to impose a civil monetary penalty not to exceed $50,000 for each violation. The Secretary may also impose other intermediate sanctions, including corrective action plans and additional monitoring in the case of a violation of this subsection.

(5) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of providers of services or suppliers (other than physicians) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse before implementing the requirements of this subsection to all providers of services and suppliers described in paragraph (3).

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(h)(1) * * *

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(5)(A) * * *

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(C)(i) * * *

(ii) For any period beginning on or after [January 1, 2010] *January 1, 2012*, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

(I) * * *

* * * * * * *

(iii) A plan described in this clause for a year for a service area is a plan described in section 1851(a)(2)(A)(i) if [the service area for the year] *the portion of the plan's service area for the year that is within the service area of a reasonable cost reimbursement contract* meets the following minimum enrollment requirements:

(I) * * *

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LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) * * *

* * * * * * *

(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) * * *

(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; [and]

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7))[.]*; and*

(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).

(3) HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) * * *

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7)); [and]

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital)[.]*; and*

(D) the hospital meets the requirements described in subsection (i)(1).

* * * * * * *

[(f) REPORTING REQUIREMENTS.—Each entity providing covered items or services for which payment may be made under this title

shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

[(1) the covered items and services provided by the entity, and

[(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently.]

(f) REPORTING AND DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

(A) the covered items and services provided by the entity, and

(B) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

(2) REQUIREMENTS FOR HOSPITALS WITH PHYSICIAN OWNERSHIP OR INVESTMENT.—In the case of a hospital that meets the requirements described in subsection (i)(1), the hospital shall—

(A) submit to the Secretary an initial report, and periodic updates at a frequency determined by the Secretary, containing a detailed description of the identity of each physician owner and physician investor and any other owners or investors of the hospital;

(B) require that any referring physician owner or investor discloses to the individual being referred, by a time that permits the individual to make a meaningful decision regarding the receipt of services, as determined by the Secretary, the ownership or investment interest, as applicable, of such referring physician in the hospital; and

(C) disclose the fact that the hospital is partially or wholly owned by one or more physicians or has one or more physician investors—

(i) on any public website for the hospital; and

(ii) in any public advertising for the hospital.

The information to be reported or disclosed under this paragraph shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirements of this paragraph shall not apply to designated health services furnished outside the United States or to entities which the Secretary determines provide services for which payment may be made under this title very infrequently.

(3) PUBLICATION OF INFORMATION.—The Secretary shall publish, and periodically update, the information submitted by hospitals under paragraph (2)(A) on the public Internet website of the Centers for Medicare & Medicaid Services.

(g) SANCTIONS.—

(1) * * *

* * * * * * *

[(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

(5) FAILURE TO REPORT OR DISCLOSE INFORMATION.—

(A) REPORTING.—Any person who is required, but fails, to meet a reporting requirement of paragraphs (1) and (2)(A) of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(B) DISCLOSURE.—Any physician who is required, but fails, to meet a disclosure requirement of subsection (f)(2)(B) or a hospital that is required, but fails, to meet a disclosure requirement of subsection (f)(2)(C) is subject to a civil money penalty of not more than $10,000 for each case in which disclosure is required to have been made.

(C) APPLICATION.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraphs (A) and (B) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

(i) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—

(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph are as follows:

(A) PROVIDER AGREEMENT.—The hospital had—

(i) physician ownership or investment on January 1, 2009; and

(ii) a provider agreement under section 1866 in effect on such date.

(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (2), the number of operating rooms, procedure rooms, or beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms, procedure rooms, or beds, respectively, as of such date.

(D) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

(i) Any ownership or investment interests that the hospital offers to a physician are not offered on more favorable terms than the terms offered to a person who is not in a position to refer patients or otherwise generate business for the hospital.

(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(v) The investment interest of the owner or investor is directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to a person that is not a physician owner or investor.

(viii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or

influencing referrals to the hospital or otherwise generating business for the hospital.

(E) PATIENT SAFETY.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to—

(i) provide assessment and initial treatment for medical emergencies; and

(ii) if the hospital lacks additional capabilities required to treat the emergency involved, refer and transfer the patient with the medical emergency to a hospital with the required capability.

(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(2) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

(A) PROCESS.—

(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which a hospital may apply for an exception from the requirement under paragraph (1)(C).

(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide persons and entities in the community in which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i). The Secretary may issue such regulations as interim final regulations.

(B) FREQUENCY.—The process described in subparagraph (A) shall permit a hospital to apply for an exception up to once every 2 years.

(C) PERMITTED INCREASE.—

(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital (or, if the hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application of the most recent increase under such an exception).

(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, or beds of a hospital

under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term "baseline number of operating rooms, procedure rooms, or beds" means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, or beds of a hospital pursuant to this paragraph may only occur in facilities on the main campus of the hospital.

(E) CONDITIONS FOR APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average bed capacity in the State is estimated to be less than the national average bed capacity;

(v) that has an average bed occupancy rate that is estimated to be greater than the average bed occupancy rate in the State in which the hospital is located; and

(vi) that meets other conditions as determined by the Secretary.

(F) PROCEDURE ROOMS.—In this subsection, the term "procedure rooms" includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished).

(G) PUBLICATION OF FINAL DECISIONS.—Not later than 120 days after receiving a complete application under this paragraph, the Secretary shall publish on the public Inter-

net website of the Centers for Medicare & Medicaid Services the final decision with respect to such application.

(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the exception process under this paragraph, including the establishment of such process, and any determination made under such process.

(3) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection and subsection (f)(2), the term "physician owner or investor" means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

(4) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital admits a patient and does not have any physician available on the premises 24 hours per day, 7 days per week, before admitting the patient—

(A) the hospital shall disclose such fact to the patient; and

(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

(5) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from terminating a hospital's provider agreement if the hospital is not in compliance with regulations pursuant to section 1866.

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

(b)(1) * * *

* * * * * * *

(14)(A) * * *

(B) For purposes of this paragraph, the term "renal dialysis services" includes—

(i) * * *

* * * * * * *

(iii) other drugs and biologicals*, including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics),* that are furnished to individuals for the treatment of end stage renal disease and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drug or biological; and

* * * * * * *

(E)(i) * * *

(ii) A provider of services or renal dialysis facility may make [a one-time election to be excluded from the phase-in] *an election, with respect to 2011, 2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)* under clause (i) and be paid entirely based on the payment amount under the payment system under this paragraph *for such year and for each subsequent year*

during the phase-in described in clause (i). Such an election shall be made prior to [January 1, 2011] *the first date of such year*, in a form and manner *and at a time* specified by the Secretary, and is final and may not be rescinded.

* * * * * * *

(15) For purposes of evaluating or auditing payments made to renal dialysis facilities for items and services under this section under paragraph (1), each such renal dialysis facility, upon the request of the Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.

* * * * * * *

(h) QUALITY INCENTIVES IN THE END-STAGE RENAL DISEASE PROGRAM.—

(1) * * *

(2) MEASURES.—

(A) * * *

(B) USE OF ENDORSED MEASURES.—

(i) * * *

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. *The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.*

* * * * * * *

(4) PERFORMANCE STANDARDS.—

(A) * * *

* * * * * * *

(E) SPECIAL RULE.—The Secretary shall initially use as the performance standard for the measures specified under paragraph (2)(A)(i) for a provider of services or a renal dialysis facility the [lesser] *greater* of—

(i) * * *

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

(b)(1) * * *

* * * * * * *

(3)(A) * * *

(B)(i) * * *

* * * * * * *

[(iii) For purposes of this subparagraph,] *(iii)(I) For purposes of this subparagraph, subject to the productivity adjustment described in subclause (II),* the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published before the promulgation of such increase for the year or period involved). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in subclause (I) minus the percentage change under this subclause.

* * * * * * *

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced *(but not below zero)* by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

* * * * * * *

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) *(determined without regard to clause (iii)(II)* for such fiscal year shall be reduced *(but not below zero)* by 33⅓ percent for fiscal year 2015, 66⅔ percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into ac-

count such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

* * * * * * *

(x)(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, the quality measures specified under clause (viii) shall be measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary shall include the rationale for continued use of such a measure in rulemaking.

* * * * * * *

(d)(1) * * *

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(5)(A) * * *

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) * * *

* * * * * * *

[(iv) Effective for discharges occurring on or after October 1, 1997] *(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009*, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located

in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of [subsection (h)(7)] *subsections (h)(7) and (h)(8)* shall apply with respect to the first sentence of this clause in the same manner as [it applies] *they apply* with respect to subsection (h)(4)(F)(i).

* * * * * * *

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in nonpatient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

* * * * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—

(A) IN GENERAL.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection.

(B) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

(i) Work effectively in various health care delivery settings, such as nonprovider settings.

(ii) Coordinate patient care within and across settings relevant to their specialties.

(iii) Understand the relevant cost and value of various diagnostic and treatment options.

(iv) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

(v) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systematic solutions in case of such errors, including experience and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

(vi) Be meaningful EHR users (as determined under section 1848(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.

* * * * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—

[Such rules] *(i) IN GENERAL.—Subject to clause (ii), such rules* shall provide that only time spent in activities relating to patient care [shall be counted and that all the time] *shall be counted and that—*

(I) effective for cost reporting periods beginning before July 1, 2009, all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting[.]*; and*

(II) effective for cost reporting periods beginning on or after July 1, 2009, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(ii) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider

setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in nonpatient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—

(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to [paragraph (7)] *paragraphs (7) and (8)*, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

* * * * * * *

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to [paragraph (7)] *paragraphs (7) and (8)*, prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

* * * * * * *

(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

(I) IN GENERAL.—The Secretary shall, by regulation, establish a process consistent with subclauses (II) and (III) under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program in a State closes on or after the date that is 2 years before the date of the enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in the State in accordance with this clause.

(II) PROCESS FOR HOSPITALS IN CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit described in subclause (I) is provided, the Secretary shall establish a process to provide for such increase to one or more hospitals located in the

State. Such process shall take into consideration the recommendations submitted to the Secretary by the senior health official (as designated by the chief executive officer of such State) if such recommendations are submitted not later than 180 days after the date of the hospital closure involved (or, in the case of a hospital that closed after the date that is 2 years before the date of the enactment of this clause, 180 days after such date of enactment).

(III) LIMITATION.—The estimated aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the estimated number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(I) TREATMENT OF CERTAIN TIME IN APPROVED MEDICAL RESIDENCY TRAINING PROGRAMING.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) * * *

* * * * * * *

(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term "nonprovider setting that is primarily engaged in furnishing patient care" means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

* * * * * * *

(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(A) * * *

* * * * * * *

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph *or under paragraph (4)(H)(vi) and paragraph (8).*

(8) ADDITIONAL REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

(i) PROGRAMS SUBJECT TO REDUCTION.—If a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as

defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) REFERENCE RESIDENT LEVEL.—

(I) IN GENERAL.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing residency training program that is not reflected on the most recent settled or submitted cost report, after audit and subject to the discretion of the Secretary, subject to subclause (IV), the reference resident level for such hospital is the resident level that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary. The Secretary is authorized to determine an alternative reference resident level for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

(III) SPECIAL PROVIDER AGREEMENT.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause is the limitation applicable under subclause (I) of such paragraph.

(IV) PREVIOUS REDISTRIBUTION.—The reference resident level specified in this clause for a hospital shall be increased to the extent required to take into account an increase in resident positions made available to the hospital under paragraph (7)(B) that are not otherwise taken into account under a previous subclause.

(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and to the extent the hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement, the Secretary shall adjust the determination of available slots accordingly, or which the Secretary otherwise has permitted the resident posi-

tions (under section 402 of the Social Security Amendments of 1967) to be aggregated for purposes of applying the resident position limitations under this subsection.

(B) REDISTRIBUTION.—

(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The estimated aggregate number of increases in the otherwise applicable resident limit under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) REQUIREMENTS FOR QUALIFYING HOSPITALS.—A hospital is not a qualifying hospital for purposes of this paragraph unless the following requirements are met:

(I) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—The hospital maintains the number of primary care residents at a level that is not less than the base level of primary care residents increased by the number of additional primary care resident positions provided to the hospital under this subparagraph. For purposes of this subparagraph, the "base level of primary care residents" for a hospital is the level of such residents as of a base period (specified by the Secretary), determined without regard to whether such positions were in excess of the otherwise applicable resident limit for such period but taking into account the application of subclauses (II) and (III) of subparagraph (A)(ii).

(II) DEDICATED ASSIGNMENT OF ADDITIONAL RESIDENT POSITIONS TO PRIMARY CARE.—The hospital assigns all such additional resident positions for primary care residents.

(III) ACCREDITATION.—The hospital's residency programs in primary care are fully accredited or, in the case of a residency training program not in operation as of the base year, the hospital is actively applying for such accreditation for the program for such additional resident positions (as determined by the Secretary).

(iii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2011, made available under this subparagraph, as determined by the Secretary.

(iv) PRIORITY FOR CERTAIN HOSPITALS.—In determining for which qualifying hospitals the increase in

the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall distribute the increase to qualifying hospitals based on the following criteria:

(I) The Secretary shall give preference to hospitals that had a reduction in resident training positions under subparagraph (A).

(II) The Secretary shall give preference to hospitals with 3-year primary care residency training programs, such as family practice and general internal medicine.

(III) The Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) that place greater emphasis upon training in Federally qualified health centers, rural health clinics, and other nonprovider settings, and to hospitals that receive additional payments under subsection (d)(5)(F) and emphasize training in an outpatient department.

(IV) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

(V) The Secretary shall give preference to hospitals that place greater emphasis upon training in a health professional shortage area (designated under section 332 of the Public Health Service Act) or a health professional needs area (designated under section 2211 of such Act).

(VI) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

(v) LIMITATION.—In no case shall more than 20 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(vi) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(vii) DISTRIBUTION.—The Secretary shall distribute the increase in resident training positions to qualifying hospitals under this subparagraph not later than July 1, 2011.

(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

(i) The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(ii) The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(D) MAINTENANCE OF PRIMARY CARE RESIDENT LEVEL.—In carrying out this paragraph, the Secretary shall require hospitals that receive additional resident positions under subparagraph (B)—

(i) to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs; and

(ii) as a condition of payment for a cost reporting period under this subsection for such positions, to maintain the level of such positions at not less than the sum of—

(I) the base level of primary care resident positions (as determined under subparagraph (B)(ii)(I)) before receiving such additional positions; and

(II) the number of such additional positions.

* * * * * * *

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT RATE.—

(A) * * *

* * * * * * *

(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase *(subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II))* in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 [and 2009] *through 2010* shall be 0 percent.

* * * * * * *

(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

(1) * * *

* * * * * * *

(3) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2010 or any subsequent rate year for a hospital, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital, such

factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).

* * * * * * *

(o) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) PRODUCTIVITY ADJUSTMENT.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2011 or any subsequent rate year for a psychiatric hospital or unit described in such paragraph, to the extent that an annual percentage increase factor applies to a base rate for such discharges for the hospital or unit, respectively, such factor shall be subject to the productivity adjustment described in subsection (b)(3)(B)(iii)(II).

(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR EXCESS READMISSIONS.—

(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

(2) BASE OPERATING DRG PAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this subsection, the term "base operating DRG payment amount" means, with respect to a hospital for a fiscal year, the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply, reduced by any portion of such amount that is attributable to payments under subparagraphs (B) and (F) of paragraph (5).

(B) ADJUSTMENTS.—For purposes of subparagraph (A), in the case of a hospital that is paid under section 1814(b)(3), the term "base operating DRG payment amount" means the payment amount under such section.

(3) ADJUSTMENT FACTOR.—

(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

(ii) the floor adjustment factor specified in subparagraph (C).

(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

(i) fiscal year 2012 is 0.99;

(ii) fiscal year 2013 is 0.98;

(iii) fiscal year 2014 is 0.97; or

(iv) a subsequent fiscal year is 0.95.

(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term "aggregate payments for excess readmissions" means, for a hospital for a fiscal year, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

(i) the base operating DRG payment amount for such hospital for such fiscal year for such condition;

(ii) the number of admissions for such condition for such hospital for such fiscal year; and

(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for the applicable period for such fiscal year minus 1.

(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term "aggregate payments for all discharges" means, for a hospital for a fiscal year, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such fiscal year.

(C) EXCESS READMISSION RATIO.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term "excess readmissions ratio" means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to the applicable period; to

(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an ap-

plicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

(iii) ADJUSTMENT.—In order to promote a reduction over time in the overall rate of readmissions for applicable conditions, the Secretary may provide, beginning with discharges for fiscal year 2014, for the determination of the excess readmissions ratio under subparagraph (C) to be based on a ranking of hospitals by readmission ratios (from lower to higher readmission ratios) normalized to a benchmark that is lower than the 50th percentile.

(5) DEFINITIONS.—For purposes of this subsection:

(A) APPLICABLE CONDITION.—The term "applicable condition" means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

(ii) measures of such readmissions—

(I) have been endorsed by the entity with a contract under section 1890(a); and

(II) such endorsed measures have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

(C) APPLICABLE HOSPITAL.—The term "applicable hospital" means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3).

(D) APPLICABLE PERIOD.—The term "applicable period" means, with respect to a fiscal year, such period as the Secretary shall specify for purposes of determining excess readmissions.

(E) READMISSION.—The term "readmission" means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as

the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) the determination of base operating DRG payment amounts;

(B) the methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5);

(C) the measures of readmissions as described in paragraph (5)(A)(ii); and

(D) the determination of a targeted hospital under paragraph (8)(B)(i), the increase in payment under paragraph (8)(B)(ii), the aggregate cap under paragraph (8)(C)(i), the hospital-specific limit under paragraph (8)(C)(ii), and the form of payment made by the Secretary under paragraph (8)(D).

(7) MONITORING INAPPROPRIATE CHANGES IN ADMISSIONS PRACTICES.—The Secretary shall monitor the activities of applicable hospitals to determine if such hospitals have taken steps to avoid patients at risk in order to reduce the likelihood of increasing readmissions for applicable conditions. If the Secretary determines that such a hospital has taken such a step, after notice to the hospital and opportunity for the hospital to undertake action to alleviate such steps, the Secretary may impose an appropriate sanction.

(8) ASSISTANCE TO CERTAIN HOSPITALS.—

(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps described in subparagraph (E) to address factors that may impact readmissions of individuals who are discharged from such a hospital, for fiscal years beginning on or after October 1, 2011, the Secretary shall make a payment adjustment for a hospital described in subparagraph (B), with respect to each such fiscal year, by a percent estimated by the Secretary to be consistent with subparagraph (C).

(B) TARGETED HOSPITALS.—Subparagraph (A) shall apply to an applicable hospital that—

(i) received (or, in the case of an 1814(b)(3) hospital, otherwise would have been eligible to receive) $10,000,000 or more in disproportionate share payments using the latest available data as estimated by the Secretary; and

(ii) provides assurances satisfactory to the Secretary that the increase in payment under this paragraph shall be used for purposes described in subparagraph (E).

(C) CAPS.—

(i) AGGREGATE CAP.—The aggregate amount of the payment adjustment under this paragraph for a fiscal year shall not exceed 5 percent of the estimated difference in the spending that would occur for such fiscal year with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

(ii) HOSPITAL-SPECIFIC LIMIT.—The aggregate amount of the payment adjustment for a hospital under this paragraph shall not exceed the estimated difference in spending that would occur for such fiscal year for such hospital with and without application of the adjustment factor described in paragraph (3) and applied pursuant to paragraph (1).

(D) FORM OF PAYMENT.—The Secretary may make the additional payments under this paragraph on a lump sum basis, a periodic basis, a claim by claim basis, or otherwise.

(E) USE OF ADDITIONAL PAYMENT.—Funding under this paragraph shall be used by targeted hospitals for transitional care activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, such as one or more of the following:

(i) Providing care coordination services to assist in transitions from the targeted hospital to other settings.

(ii) Hiring translators and interpreters.

(iii) Increasing services offered by discharge planners.

(iv) Ensuring that individuals receive a summary of care and medication orders upon discharge.

(v) Developing a quality improvement plan to assess and remedy preventable readmission rates.

(vi) Assigning discharged individuals to a medical home.

(vii) Doing other activities as determined appropriate by the Secretary.

(F) GAO REPORT ON USE OF FUNDS.—Not later than 3 years after the date on which funds are first made available under this paragraph, the Comptroller General of the United States shall submit to Congress a report on the use of such funds.

(G) DISPROPORTIONATE SHARE HOSPITAL PAYMENT.—In this paragraph, the term "disproportionate share hospital payment" means an additional payment amount under subsection (d)(5)(F).

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PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * * * *

(e) PROSPECTIVE PAYMENT.—

(1) * * *

(2) DEFINITIONS.—For purposes of this subsection:

(A) COVERED SKILLED NURSING FACILITY SERVICES.—

(i) * * *

(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) and (ii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, *clinical social worker services, marriage and family therapist services (as defined in subsection (jjj)(1)), mental health counselor services (as defined in section 1861(kkk)(1)),* services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1861(s)(2), telehealth services furnished under section 1834(m)(4)(C)(ii)(VII), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

* * * * * * *

(4) FEDERAL PER DIEM RATE.—

(A) * * *

* * * * * * *

(E) UPDATING.—

(i) * * *

(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) * * *

* * * * * * *

(III) for each of fiscal years 2002 and 2003, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 0.5 percentage points; **[**and**]**

(IV) for each of fiscal years 2004 through 2009, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

(V) for fiscal year 2010, the rate computed for the previous fiscal year; and

[(IV)**]** *(VI)* for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

* * * * * * *

(5) SKILLED NURSING FACILITY MARKET BASKET INDEX AND PERCENTAGE.—For purposes of this subsection:

(A) * * *

(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term "skilled nursing facility market basket

percentage" means, for a fiscal year or other annual period and as calculated by the Secretary *subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)*, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

* * * * * * *

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), adjustments for variations in labor-related costs under paragraph (4)(G)(ii), **[**and**]** adjustments under paragraph (4)(G)(iii)*, and adjustment under section 1111(b) of the America's Affordable Health Choices Act of 2009*;

(B) the establishment of facility specific rates before July 1, 1999 (except any determination of costs paid under part A of this title); **[**and**]**

(C) the establishment of transitional amounts under paragraph (7)**[**.**]***; and*

(D) the establishment of outliers under paragraph (13).

* * * * * * *

(13) OUTLIERS FOR NTA AND THERAPY.—

(A) IN GENERAL.—With respect to outliers because of unusual variations in the type or amount of medically necessary care, beginning with October 1, 2010, the Secretary—

(i) shall provide for an addition or adjustment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers; and

(ii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to therapy services in the case of such outliers.

(B) OUTLIERS BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

(C) BUDGET NEUTRALITY.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year may not exceed 2 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.

(f) REPORTING OF DIRECT CARE EXPENDITURES.—

(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 3 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

(A) Spending on direct care services (including nursing, therapy, and medical services).

(B) Spending on indirect care (including housekeeping and dietary services).

(C) Capital assets (including building and land costs).

(D) Administrative services costs.

(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.

* * * * * * *

CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT

SEC. 1890. (a) * * *

(b) DUTIES.—The duties described in this subsection are the following:

(1) * * *

(2) ENDORSEMENT OF MEASURES.—The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

(A) * * *

* * * * * * *

If the entity does not endorse a measure, such entity shall explain the reasons and provide suggestions about changes to

such measure that might make it a potentially endorsable measure.

* * * * * * *

(d) FUNDING.—For purposes of carrying out this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account ⟦for each of fiscal years 2009 through 2012⟧ *for fiscal year 2009, and $12,000,000 for each of the fiscal years 2010 through 2012*.

* * * * * * *

MEDICARE INTEGRITY PROGRAM

SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities*, or otherwise,* to carry out the activities described in subsection (b).

* * * * * * *

(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) * * *

* * * * * * *

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement; ⟦and⟧

(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and

⟦(4)⟧ *(5)* the entity meets such other requirements as the Secretary may impose.

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) * * *

* * * * * * *

(III) For periods beginning after the period described in subclause (II) *and before 2011*, such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

(IV) Subject to clause (iii)(I), for 2011, such amount (or amounts) shall be adjusted by a uniform percentage determined to be appropriate by the Secretary based on analysis of factors such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant.

(V) Subject to clause (iii)(II), for a year after 2011, such a amount (or amounts) shall be equal to the amount (or amounts) determined under this clause for the previous year, updated under subparagraph (B).

* * * * * * *

(iii) SPECIAL RULE IN CASE OF INABILITY TO EFFECT TIMELY REBASING.—

(I) APPLICATION OF PROXY AMOUNT FOR 2011.—If the Secretary is not able to compute the amount (or amounts) under clause (i)(IV) so as to permit, on a timely basis, the application of such clause for 2011, the Secretary shall substitute for such amount (or amounts) 95 percent of the amount (or amounts) that would otherwise be specified under clause (i)(III) if it applied for 2011.

(II) ADJUSTMENT FOR SUBSEQUENT YEARS BASED ON DATA.—If the Secretary applies subclause (I), the Secretary before July 1, 2011, shall compare the amount (or amounts) applied under such subclause with the amount (or amounts) that should have been applied under clause (i)(IV). The Secretary shall decrease or increase the prospective payment amount (or amounts) under clause (i)(V) for 2012 (or, at the Secretary's discretion, over a period of several years beginning with 2012) by the amount (if any) by which the amount (or amounts) applied under subclause (I) is greater or less, respectively, than the amount (or amounts) that should have been applied under clause (i)(IV).

(B) ANNUAL UPDATE.—

(i) * * *

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term

"home health applicable increase percentage" means, with respect to—

(I) * * *

* * * * * * *

(IV) 2006, 0 percent; [and]

(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;

(VI) 2010, subject to clause (v), 0 percent; and

[(V)] *(VII)* any subsequent year, subject to clause (v), the home health market basket percentage increase.

(iii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term "home health market basket percentage increase" means, with respect to a fiscal year or year, a percentage (estimated by the Secretary before the beginning of the fiscal year or year) determined and applied with respect to the mix of goods and services included in home health services in the same manner *(including being subject to the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))* as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year.

(iv) ADJUSTMENT FOR CASE MIX CHANGES.—[Insofar as] *Subject to clause (vi), insofar as* the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year (or estimates that such adjustments for a future fiscal year or year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year or year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years or years so as to eliminate the effect of such coding or classification changes.

(v) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

(I) ADJUSTMENT.—For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced *(but not below 0)* by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission

shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.

* * * * * * *

(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—

(I) IN GENERAL.—With respect to the case mix adjustments established in section 484.220(a) of title 42, Code of Federal Regulations, the Secretary shall apply, in 2010, the adjustment established in paragraph (3) of such section for 2011, in addition to applying the adjustment established in paragraph (2) for 2010.

(II) CONSTRUCTION.—Nothing in this clause shall be construed as limiting the amount of adjustment for case mix for 2010 or 2011 if more recent data indicate an appropriate adjustment that is greater than the amount established in the section described in subclause (I).

* * * * * * *

MEDICARE IMPROVEMENT FUND

SEC. 1898. (a) * * *

(b) FUNDING.—

(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for services furnished during—

[(A) fiscal year 2014, $22,290,000,000; and**]**

(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(9) provide—

(A) * * *

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, **[**and**]**

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (16) and (17) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G)**[**;**]**, *and*

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all

skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

* * * * * * *

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g) and in section 1915, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan *or by a person to whom or entity to which a moratorium under section 1128G(a)(4) is applied during the period of such moratorium*;

* * * * * * *

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services; **[**and**]**

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) * * *

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title**[**.**]***; and*

(74) provide that the State will enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such sub-

section (a) through use of the appropriate procedures described in such subsection (a)) or subsection (b) of such section (relating to disclosure requirements), and that the State will carry out any activities as required by the Secretary for purposes of such subsection (a) and apply any enhanced safeguards, with respect to a provider or supplier described in such subsection (b), as the Secretary determines necessary under such subsection (b).

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

* * * * * * *

(o)(1) * * *

* * * * * * *

(4) The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner as such provisions apply to a hospice program providing hospice care under title XVIII.

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) * * *

* * * * * * *

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, [effective beginning with January 1, 2010] *effective for the period beginning with January 1, 2010, and ending with December 31, 2011*, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be) *or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).*

* * * * * * *

REQUIREMENTS FOR NURSING FACILITIES

SEC. 1919. (a) * * *

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) * * *

(B) QUALITY ASSESSMENT AND [ASSURANCE] *ASSURANCE AND QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.*—

(i) IN GENERAL.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.

(ii) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this clause referred to as the "QAPI program") for nursing facilities, including multi-unit chains of such facilities. Under the QAPI program, the Secretary shall establish standards relating to such facilities and provide technical assistance to such facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under subclause (II), a nursing facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under clause (i).

(II) REGULATIONS.—The Secretary shall promulgate regulations to carry out this clause.

* * * * * * *

(8) INFORMATION ON NURSE STAFFING.—

(A) * * *

* * * * * * *

(C) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(i) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational

nurse, certified nursing assistant, therapist, or other medical personnel);

(ii) include resident census data and information on resident case mix;

(iii) include a regular reporting schedule; and

(iv) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in clause (i) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph with respect to agency and contract staff shall be kept separate from information on employee staffing.

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) * * *

* * * * * * *

(9) NOTIFICATION OF FACILITY CLOSURE.—

(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

(I) subject to subclause (II), not later than the date that is 60 days prior to the date of such closure; and

(II) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

(ii) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

(B) RELOCATION.—

(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under subparagraph (A) during the period beginning on the date such notifi-

cation is submitted and ending on the date on which the resident is successfully relocated.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(A) * * *

[(B) REQUIRED NOTICES.—If a change occurs in—

[(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

[(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

[(iii) the corporation, association, or other company responsible for the management of the facility, or

[(iv) the individual who is the administrator or director of nursing of the facility,

nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.]

[(C)] *(B)* NURSING FACILITY ADMINISTRATOR.—The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(C) COMPLIANCE AND ETHICS PROGRAM.—

(i) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this subparagraph, a nursing facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the "operating organization" or "organization"), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under clause (ii).

(ii) DEVELOPMENT OF REGULATIONS.—

(I) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall develop regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

(II) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal and rigorous program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi-unit nursing home chains.

(III) EVALUATION.—Not later than 3 years after the date of promulgation of regulations under this clause the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subparagraph. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of resident quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

(iii) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subparagraph, the term "compliance and ethics program" means, with respect to a nursing facility, a program of the operating organization that—

(I) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(II) includes at least the required components specified in clause (iv).

(iv) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an organization are the following:

(I) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and has sufficient resources and authority to assure such compliance.

(III) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(IV) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(V) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal,

civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(VI) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(VII) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

(VIII) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

(v) COORDINATION.—The provisions of this subparagraph shall apply with respect to a nursing facility in lieu of section 1902(a)(77).

(D) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

* * * * * * *

(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—As a condition of approval of its plan under this title, a State must provide for the following:

(1) * * *

* * * * * * *

(8) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

(i) a resident of a nursing facility;

(ii) any person acting on the resident's behalf; and

(iii) any person who works at a nursing facility or a representative of such a worker.

(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure

that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party has complained, in good faith, about the quality of care or other issues relating to the nursing facility, that the legal representative of a resident of a nursing facility or other responsible party is not denied access to such resident or otherwise retaliated against if such representative party has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services or an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, other responsible party, or worker used the form developed under subsection (f)(11) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(C) WHISTLEBLOWER PROTECTION.—

(i) PROHIBITION AGAINST RETALIATION.—No person who works at a nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person's request) complained, in good faith, about the quality of care or services provided by a nursing facility or about other issues relating to quality of care or services, whether using the form developed under subsection (f)(11) or some other method for submitting the complaint.

(ii) RETALIATORY REPORTING.—A nursing facility may not file a complaint or a report against a person who works (or has worked at the facility with the appropriate State professional disciplinary agency because the person (or anyone acting at the person's request) complained in good faith, as described in clause (i).

(iii) COMMENCEMENT OF ACTION.—Any person who believes the person has been penalized, discriminated, or retaliated against or had a contract for services terminated in violation of clause (i) or against whom a complaint has been filed in violation of clause (ii) may

bring an action at law or equity in the appropriate district court of the United States, which shall have jurisdiction over such action without regard to the amount in controversy or the citizenship of the parties, and which shall have jurisdiction to grant complete relief, including, but not limited to, injunctive relief (such as reinstatement, compensatory damages (which may include reimbursement of lost wages, compensation, and benefits), costs of litigation (including reasonable attorney and expert witness fees), exemplary damages where appropriate, and such other relief as the court deems just and proper.

(iv) RIGHTS NOT WAIVABLE.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

(v) REQUIREMENT TO POST NOTICE OF EMPLOYEE RIGHTS.—Each nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a nursing facility that violates the provisions of this paragraph and information with respect to the manner of filing such a complaint.

(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a resident of a nursing facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under subsection (f)(11) (including submitting a complaint orally).

(E) GOOD FAITH DEFINED.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

(i) the information reported or disclosed in the complaint is true; and

(ii) the violation of this title has occurred or may occur in relation to such information.

(f) RESPONSIBILITIES OF SECRETARY RELATING TO NURSING FACILITY REQUIREMENTS.—

(1) * * *

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and

social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum *(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training)*, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

* * * * * * *

(10) SPECIAL FOCUS FACILITY PROGRAM.—

(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.

(11) STANDARDIZED COMPLAINT FORM.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) * * *

* * * * * * *

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) * * *

* * * * * * *

(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) ENFORCEMENT PROCESS.—

(1) * * *

(2) SPECIFIED REMEDIES.—

(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) * * *

(ii) [A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d).] *A civil money penalty in accordance with subparagraph (G).* Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost*, and some portion of such funds may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, providing technical assistance to facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).*

* * * * * * *

(G) CIVIL MONEY PENALTIES.—

(i) IN GENERAL.—The State may impose a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subclause (II) and (III)) for each day or instance, respectively, of noncompliance (as determined appropriate by the Secretary).

(ii) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term "applicable per instance amount" means—

(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000.

(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

(III) in each case of any other deficiency, an amount not less than $250 and not to exceed $3050.

(iii) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term "applicable per day amount" means—

(I) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

(iv) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

(v) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the penalty is imposed for a deficiency described in clause (ii)(II) or (iii)(I) and the actual harm or widespread harm that immediately jeopardizes the health or safety of a resident or residents of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (iv) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver or an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

(vi) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under subparagraph (A)(ii), the State—

(I) subject to subclause (III), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the State survey agency for making final recommendations for such penalties;

(II) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty

and ending on the day on which the informal dispute resolution process under subclause (I) is completed;

(III) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the State on the earlier of the date on which the informal dispute resolution process under subclause (I) is completed or the date that is 90 days after the date of the imposition of the penalty;

(IV) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(V) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(VI) in the case where all such appeals are unsuccessful, may provide that such funds collected shall be used for the purposes described in the second sentence of subparagraph (A)(ii).

(3) SECRETARIAL AUTHORITY.—

(A) * * *

* * * * * * *

(C) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) * * *

[(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

(I) AMOUNT.—Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) PROHIBITION ON REDUCTION FOR REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the

facility in the preceding year under such subclause with respect to a repeat deficiency.

(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary—

(aa) subject to item (bb), shall, not later than 30 days after the date of imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, shall not impose a penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).

(V) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and except to the extent that such provisions require a

hearing prior to the imposition of a civil money penalty) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

(8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) *and in paragraph (3)(C)(ii)* may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.

* * * * * * *

(i) NURSING HOME COMPARE WEBSITE.—

(1) INCLUSION OF ADDITIONAL INFORMATION.—

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the "Nursing Home Compare" Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under subsection (b)(8)(C)(ii), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting "nursing home staff hours per resident day");

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such re-

ports, and the facility plan of correction or other response to such report.

(iii) The standardized complaint form developed under subsection (f)(10), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by employees of a nursing facility—

(I) that were committed inside of the facility; and

(II) with respect to such instances of violations or crimes committed outside of the facility, that were the violations or crimes that resulted in the serious bodily injury of an elder.

(B) DEADLINE FOR PROVISION OF INFORMATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(4) and subsection (b)(8)(C)(ii) are implemented.

(2) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups;

(iv) skilled nursing facility employees and their representatives; and

(v) any other representatives of programs or groups the Secretary determines appropriate.

[(i)**]** *(j)* CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obliga-

tions under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

* * * * * * *

PAYMENT FOR COVERED OUTPATIENT DRUGS

SEC. 1927. (a) * * *

(b) TERMS OF REBATE AGREEMENT.—

(1) * * *

* * * * * * *

(3) MANUFACTURER PROVISION OF PRICE INFORMATION.—

(A) IN GENERAL.—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

(i) * * *

* * * * * * *

(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

(I) * * *

* * * * * * *

(III) information on those sales that were made at a nominal price or otherwise described in section 1847A(c)(2)(B);

for a drug or biological described in subparagraph *(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),* (C), (D), (E), or (G) of section 1842(o)(1) or section 1881(b)(13)(A)(ii), and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs.

* * * * * * *

TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* * * * * * *

SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

(a) * * *

* * * * * * *

(d) PROGRAM INTEGRITY.—A State child health plan shall include a description of the procedures to be used by the State—

(1) to enforce any determination made by the Secretary under subsection (a) of section 1128G (relating to a significant risk of fraudulent activity with respect to a category of provider or supplier described in such subsection through use of the appropriate procedures described in such subsection);

(2) to carry out any activities as required by the Secretary for purposes of such subsection; and

(3) to enforce any determination made by the Secretary under subsection (b) of section 1128G (relating to disclosure requirements) and to apply any enhanced safeguards, with respect to

a provider or supplier described in such subsection, as the Secretary determines necessary under such subsection.

* * * * * * *

SEC. 2114. ASSURING QUALITY OF CARE IN HOSPICE CARE.

The provisions of section 1819A shall apply to a hospice program providing hospice care under this title in the same manner such provisions apply to a hospice program providing hospice care under title XVIII.

INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

PART I—TAX ON INDIVIDUALS

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Part VIII. Health Care Related Taxes.

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PART IV—CREDITS AGAINST TAX

* * * * * * *

Subpart D—Business Related Credits

Sec. 38. General business credit.

* * * * * * *

Sec. 45R. Small business employee health coverage credit.

* * * * * * *

SEC. 38. GENERAL BUSINESS CREDIT.

(a) * * *

(b) CURRENT YEAR BUSINESS CREDIT.—For purposes of this subpart, the amount of the current year business credit is the sum of the following credits determined for the taxable year:

(1) * * *

* * * * * * *

(34) the carbon dioxide sequestration credit determined under section 45Q(a) **[**plus**]**

(35) the portion of the new qualified plug-in electric drive motor vehicle credit to which section 30D(c)(1) applies**[.]**, *plus*

(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business employee health coverage credit determined under section 45R(a).

* * * * * * *

SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

(a) IN GENERAL.—For purposes of section 38, in the case of a qualified small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(b) APPLICABLE PERCENTAGE.—

(1) IN GENERAL.—For purposes of this section, the applicable percentage is 50 percent.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION OF EMPLOYEES.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

(c) LIMITATIONS.—

(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as—

(A) the excess of—

(i) the number of qualified employees employed by the employer during the taxable year, over

(ii) 10, bears to

(B) 15.

(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No credit shall be allowed under subsection (a) with respect to qualified employee health coverage expenses paid or incurred with respect to any employee for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $80,000.

(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EXPENSES.—For purposes of this section—

(1) IN GENERAL.—The term "qualified employee health coverage expenses" means, with respect to any employer for any taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage.

(2) QUALIFIED HEALTH COVERAGE.—The term "qualified health coverage" means acceptable coverage (as defined in section 59B(d)) which—

(A) is provided pursuant to an election under section 4980H(a), and

(B) satisfies the requirements referred to in section 4980H(c).

(e) OTHER DEFINITIONS.—For purposes of this section—

(1) QUALIFIED SMALL EMPLOYER.—For purposes of this section, the term "qualified small employer" means any employer for any taxable year if—

(A) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

(B) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

(2) QUALIFIED EMPLOYEE.—The term "qualified employee" means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation from such employer for services performed in the trade or business of such employer during such taxable year.

(3) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term "average annual employee compensation" means, with respect to any employer for any taxable year, the average amount of compensation paid by such employer to qualified employees of such employer during such taxable year.

(4) COMPENSATION.—The term "compensation" has the meaning given such term in section 408(p)(6)(A).

(5) FAMILY COVERAGE.—The term "family coverage" means any coverage other than self-only coverage.

(f) SPECIAL RULES.—For purposes of this section—

(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined without regard to this paragraph) with respect to whom the election under 4980H(a) applies, each partner (or, in the case of a trade or business carried on by an individual, such individual) shall be treated as an employee.

(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

(3) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance coverage to which subsection (a) applies shall be reduced by the amount of the credit determined under this section.

(4) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each of the dollar amounts in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined by substituting "calendar year 2012" for "calendar year 1992" in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

* * * * * * *

PART VIII—HEALTH CARE RELATED TAXES

SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

Subpart A—Tax on Individuals Without Acceptable Health Care Coverage

Sec. 59B. Tax on individuals without acceptable health care coverage.

SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) TAX IMPOSED.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the excess of—

(1) the taxpayer's modified adjusted gross income for the taxable year, over

(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(b) LIMITATIONS.—

(1) TAX LIMITED TO AVERAGE PREMIUM.—

(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the applicable national average premium for such taxable year.

(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

(i) IN GENERAL.—For purposes of subparagraph (A), the "applicable national average premium" means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the case of any taxpayer who fails to meet the requirements of subsection (e) with respect to more than one individual during the taxable year, clause (i) shall be applied by substituting "family coverage" for "self-only coverage".

(2) PRORATION FOR PART YEAR FAILURES.—The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of paragraph (1)) as—

(A) the aggregate periods during such taxable year for which such individual failed to meet the requirements of subsection (d), bears to

(B) the entire taxable year.

(c) EXCEPTIONS.—

(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer

for any taxable year beginning in the same calendar year as such taxable year.

(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a nonresident alien.

(3) INDIVIDUALS RESIDING OUTSIDE UNITED STATES.—Any qualified individual (as defined in section 911(d)) (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1), whichever is applicable.

(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

(5) RELIGIOUS CONSCIENCE EXEMPTION.—

(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

(B) EXEMPTION.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such form and manner as the Secretary may prescribe. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

(d) ACCEPTABLE COVERAGE REQUIREMENT.—

(1) IN GENERAL.—The requirements of this subsection are met with respect to any individual for any period if such individual (and each qualifying child of such individual) is covered by acceptable coverage at all times during such period.

(2) ACCEPTABLE COVERAGE.—For purposes of this section, the term "acceptable coverage" means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the America's Affordable Health Choices Act of 2009).

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRANDFATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102 of the America's Affordable Health Choices Act of 2009) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title

10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary in coordination with the Health Choices Commissioner to be not less than the level specified by the Secretary of the Treasury, in coordination with the Secretary of Veteran's Affairs and the Health Choices Commissioner, based on the individual's priority for services as provided under section 1705(a) of such title.

(G) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

(e) OTHER DEFINITIONS AND SPECIAL RULES.—

(1) QUALIFYING CHILD.—For purposes of this section, the term "qualifying child" has the meaning given such term by section 152(c). With respect to any period during which health coverage for a child must be provided by an individual pursuant to a child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

(2) BASIC PLAN.—For purposes of this section, the term "basic plan" has the meaning given such term under section 100(c) of the America's Affordable Health Choices Act of 2009.

(3) HEALTH INSURANCE EXCHANGE.—For purposes of this section, the term "Health Insurance Exchange" has the meaning given such term under section 100(c) of the America's Affordable Health Choices Act of 2009, including any State-based health insurance exchange approved for operation under section 208 of such Act.

(4) FAMILY COVERAGE.—For purposes of this section, the term "family coverage" means any coverage other than self-only coverage.

(5) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term "modified adjusted gross income" means adjusted gross income—

(A) determined without regard to section 911, and

(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

(2) a process for applying for a waiver of the application of subsection (a) in cases of hardship.

Subpart B—Surcharge on High Income Individuals

Sec. 59C. Surcharge on high income individuals.

SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to—

(1) 1 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $350,000 but does not exceed $500,000,

(2) 1.5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000 but does not exceed $1,000,000, and

(3) 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting for each of the dollar amounts therein (after any increase determined under subsection (e)) a dollar amount equal to—

(1) 50 percent of the dollar amount so in effect in the case of a married individual filing a separate return, and

(2) 80 percent of the dollar amount so in effect in any other case.

(c) ADJUSTMENTS BASED ON FEDERAL HEALTH REFORM SAVINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), in the case of any taxable year beginning after December 31, 2012, subsection (a) shall be applied—

(A) by substituting "2 percent" for "1 percent", and

(B) by substituting "3 percent" for "1.5 percent".

(2) ADJUSTMENTS BASED ON EXCESS FEDERAL HEALTH REFORM SAVINGS.—

(A) EXCEPTION IF FEDERAL HEALTH REFORM SAVINGS SIGNIFICANTLY EXCEEDS BASE AMOUNT.—If the excess Federal health reform savings is more than $150,000,000,000 but not more than $175,000,000,000, paragraph (1) shall not apply.

(B) FURTHER ADJUSTMENT FOR ADDITIONAL FEDERAL HEALTH REFORM SAVINGS.—If the excess Federal health reform savings is more than $175,000,000,000, paragraphs (1) and (2) of subsection (a) (and paragraph (1) of this subsection) shall not apply to any taxable year beginning after December 31, 2012.

(C) EXCESS FEDERAL HEALTH REFORM SAVINGS.—For purposes of this subsection, the term "excess Federal health reform savings" means the excess of—

(i) the Federal health reform savings, over

(ii) $525,000,000,000.

(D) FEDERAL HEALTH REFORM SAVINGS.—The term "Federal health reform savings" means the sum of the amounts described in subparagraphs (A) and (B) of paragraph (3).

(3) DETERMINATION OF FEDERAL HEALTH REFORM SAVINGS.—Not later than December 1, 2012, the Director of the Office of Management and Budget shall—

(A) determine, on the basis of the study conducted under paragraph (4), the aggregate reductions in Federal expenditures which have been achieved as a result of the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009 during the period beginning on October 1, 2009, and ending with the latest date with respect to which the Director has sufficient data to make such determination, and

(B) estimate, on the basis of such study and the determination under subparagraph (A), the aggregate reductions in Federal expenditures which will be achieved as a result of such provisions and amendments during so much of the period beginning with fiscal year 2010 and ending with fiscal year 2019 as is not taken into account under subparagraph (A).

(4) STUDY OF FEDERAL HEALTH REFORM SAVINGS.—The Director of the Office of Management and Budget shall conduct a study of the reductions in Federal expenditures during fiscal years 2010 through 2019 which are attributable to the provisions of, and amendments made by, division B of the America's Affordable Health Choices Act of 2009. The Director shall complete such study not later than December 1, 2012.

(5) REDUCTIONS IN FEDERAL EXPENDITURES DETERMINED WITHOUT REGARD TO PROGRAM INVESTMENTS.—For purposes of paragraphs (3) and (4), reductions in Federal expenditures shall be determined without regard to section 1121 of the America's Affordable Health Choices Act of 2009 and other program investments under division B thereof.

(d) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term "modified adjusted gross income" means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

(e) INFLATION ADJUSTMENTS.—

(1) IN GENERAL.—In the case of taxable years beginning after 2011, the dollar amounts in subsection (a) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting "calendar year 2010" for "calendar year 1992" in subparagraph (B) thereof.

(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $5,000, such amount shall be rounded to the next lowest multiple of $5,000.

(f) SPECIAL RULES.—

(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with

the tax imposed under section 871(b) shall be taken into account under this section.

(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amounts in effect under subsection (a) (after the application of subsections (b) and (e)) shall be decreased by the excess of—

(A) the amounts excluded from the taxpayer's gross income under section 911, over

(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

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Subchapter B—Computation of Taxable Income

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

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SEC. 105. AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.

(a) * * *

(b) AMOUNTS EXPENDED FOR MEDICAL CARE.—Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts referred to in subsection (a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d)) of the taxpayer, his spouse, [and his dependents] *his dependents* (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) *and any eligible beneficiary (within the meaning of section 106(f)) with respect to the taxpayer*. Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection.

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SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) * * *

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(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug or is insulin.

(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term "eligible beneficiary" means any individual who is eligible to receive benefits or coverage under an accident or health plan.

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PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

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SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) * * *

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(l) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

[(1) ALLOWANCE OF DEDUCTION.—

[(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

[(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

[For taxable years beginning in calendar year -	The applicable percentage is -
1999 through 2001	60
2002	70
2003 and thereafter	100.]

(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

(A) the taxpayer,

(B) the taxpayer's spouse,

(C) the taxpayer's dependents, and

(D) any individual who—

(i) satisfies the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

(iii) meets the requirements of section 152(d)(1)(C), and

(E) one individual who—

(i) does not satisfy the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

(iii) meets the requirements of section 152(d)(1)(D), and

(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).

(2) LIMITATIONS.—

(A) * * *

(B) OTHER COVERAGE.—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse*, any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to* of the taxpayer. The preceding sentence shall be applied separately with respect to—

(i) * * *

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PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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SEC. 220. ARCHER MSAS.

(a) * * *

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(d) ARCHER MSA.—For purposes of this section—

(1) * * *

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term "qualified medical expenses" means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. *Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.*

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SEC. 223. HEALTH SAVINGS ACCOUNTS.

(a) * * *

* * * * * * *

(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

(1) * * *

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term "qualified medical expenses" means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) for such individual, the spouse of such indi-

vidual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. *Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.*

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Subchapter F—Exempt Organizations

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PART I—GENERAL RULE

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SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

(a) * * *

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(c) LIST OF EXEMPT ORGANIZATIONS.—The following organizations are referred to in subsection (a):

(1) * * *

* * * * * * *

(9) Voluntary employees' beneficiary associations providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inures (other than through such payments) to the benefit of any private shareholder or individual. *For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term "dependents" shall include any individual who is an eligible beneficiary (within the meaning of section 106(f)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.*

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Subchapter N—Tax Based on Income From Sources Within or Without the United States

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PART I—SOURCE RULES AND OTHER GENERAL RULES RELATING TO FOREIGN INCOME

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SEC. 864. DEFINITIONS AND SPECIAL RULES.

(a) * * *

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(f) ELECTION TO ALLOCATE INTEREST, ETC. ON WORLDWIDE BASIS.—For purposes of this subchapter, at the election of the worldwide affiliated group—

(1) * * *

* * * * * * *

(5) ELECTION TO EXPAND FINANCIAL INSTITUTION GROUP OF WORLDWIDE.—group (A) * * *

* * * * * * *

(D) ELECTION.—An election under this paragraph with respect to any financial institution group may be made only by the common parent of the pre-election worldwide affiliated group and may be made only for the first taxable year beginning after [December 31, 2010] *December 31, 2019*, in which such affiliated group includes 1 or more financial corporations. Such an election, once made, shall apply to all financial corporations which are members of the electing financial institution group for such taxable year and all subsequent years unless revoked with the consent of the Secretary.

* * * * * * *

(6) ELECTION.—An election to have this subsection apply with respect to any worldwide affiliated group may be made only by the common parent of the domestic affiliated group referred to in paragraph (1)(C) and may be made only for the first taxable year beginning after [December 31, 2010] *December 31, 2019*, in which a worldwide affiliated group exists which includes such affiliated group and at least 1 foreign corporation. Such an election, once made, shall apply to such common parent and all other corporations which are members of such worldwide affiliated group for such taxable year and all subsequent years unless revoked with the consent of the Secretary.

[(7) TRANSITION.—In the case of the first taxable year to which this subsection applies, the increase (if any) in the amount of the interest expense allocable to sources within the United States by reason of the application of this subsection shall be 30 percent of the amount of such increase determined without regard to this paragraph.]

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PART II—NONRESIDENT ALIENS AND FOREIGN CORPORATIONS

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Subpart D—Miscellaneous Provisions

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SEC. 894. INCOME AFFECTED BY TREATY.

(a) * * *

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(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term "deductible related-party payment" means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are members of the same foreign controlled group of entities.

(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

(A) IN GENERAL.—The term "foreign controlled group of entities" means a controlled group of entities the common parent of which is a foreign corporation.

(B) CONTROLLED GROUP OF ENTITIES.—The term "controlled group of entities" means a controlled group of corporations as defined in section 1563(a)(1), except that—

(i) "more than 50 percent" shall be substituted for "at least 80 percent" each place it appears therein, and

(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term "foreign parent corporation" means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.

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Subtitle C—Employment Taxes

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter B—Tax on Employers

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SEC. 3111. RATE OF TAX.

(a) * * *

* * * * * * *

(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

(2) SPECIAL RULES FOR SMALL EMPLOYERS.—

(A) IN GENERAL.—In the case of any employer who is small employer for any calendar year, paragraph (1) shall be applied by substituting the applicable percentage determined in accordance with the following table for "8 percent":

If the annual payroll of such employer for the preceding calendar year:	***The applicable percentage is:***
Does not exceed $250,000	*0 percent*
Exceeds $250,000, but does not exceed $300,000	*2 percent*
Exceeds $300,000, but does not exceed $350,000	*4 percent*
Exceeds $350,000, but does not exceed $400,000	*6 percent*

(B) SMALL EMPLOYER.—For purposes of this paragraph, the term "small employer" means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $400,000.

(C) ANNUAL PAYROLL.—For purposes of this paragraph, the term "annual payroll" means, with respect to any employer for any calendar year, the aggregate wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)) during such calendar year.

(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term "nonelecting employer" means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

(5) AGGREGATION; PREDECESSORS.—For purposes of this subsection—

(A) all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer, and

(B) any reference to any person shall be treated as including a reference to any predecessor of such person.

[(c)] *(d)* RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by [this section] *subsections (a) and (b)* to the extent that such wages are subject under such agreement exclusively to the laws applicable to the social security system of such foreign country.

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Subchapter C—General Provisions

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SEC. 3121. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) * * *

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee [or any of his dependents]*, any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee* under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*) or for a class or classes of his employees (or for a class or classes of his employees [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*), on account of—

(A) sickness or accident disability (but, in the case of payments made to an employee [or any of his dependents,]*, any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,* this subparagraph shall exclude from the term "wages" only payments which are received under a workman's compensation law), or

* * * * * * *

(aa) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3111(c)—

(1) Paragraphs (1), (5), and (19) of subsection (b) shall not apply.

(2) Paragraph (7) of subsection (b) shall apply by treating all services as not covered by the retirement systems referred to in subparagraphs (C) and (F) thereof.

(3) Subsection (e) shall not apply and the term "State" shall include the District of Columbia.

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CHAPTER 22—RAILROAD RETIREMENT TAX ACT

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Subchapter C—Tax on Employers

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SEC. 3221. RATE OF TAX.

(a) * * *

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(c) EMPLOYERS ELECTING TO NOT PROVIDE HEALTH BENEFITS.—

(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every nonelecting employer an excise tax, with respect to having individuals in his employ, equal to 8 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.

(2) EXCEPTION FOR SMALL EMPLOYERS.—Rules similar to the rules of section 3111(c)(2) shall apply for purposes of this subsection.

(3) NONELECTING EMPLOYER.—For purposes of paragraph (1), the term "nonelecting employer" means any employer for any period with respect to which such employer does not have an election under section 4980H(a) in effect.

(4) SPECIAL RULE FOR SEPARATE ELECTIONS.—In the case of an employer who makes a separate election described in section 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking into account only the wages paid to employees who are not subject to such election.

[(c)**]** *(d)* CROSS REFERENCE.—For application of different contribution bases with respect to the taxes imposed by **[**subsections (a) and (b), see section 3231(e)(2)**]** *this section, see paragraphs (2) and (13)(B) of section 3231(e).*

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Subchapter D—General Provisions

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SEC. 3231. DEFINITIONS.

(a) * * *

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(e) COMPENSATION.—For purposes of this chapter—

(1) The term "compensation" means any form of money remuneration paid to an individual for services rendered as an employee to one or more employers. Such term does not include (i) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund,

to provide for any such payment) made to, or on behalf of, an employee [or any of his dependents], *any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,* under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*) or for a class or classes of his employees (or for a class or classes of his employees [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*), on account of sickness or accident disability or medical or hospitalization expenses in connection with sickness or accident disability or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee, (ii) tips (except as is provided under paragraph (3)), (iii) an amount paid specifically - either as an advance, as reimbursement or allowance - for traveling or other bona fide and necessary expenses incurred or reasonably expected to be incurred in the business of the employer provided any such payment is identified by the employer either by a separate payment or by specifically indicating the separate amounts where both wages and expense reimbursement or allowance are combined in a single payment, or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5). Such term does not include remuneration for service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q), as the case may be. For the purpose of determining the amount of taxes under sections 3201 and 3221, compensation earned in the service of a local lodge or division of a railway-labor-organization employer shall be disregarded with respect to any calendar month if the amount thereof is less than $25. Compensation for service as a delegate to a national or international convention of a railway labor organization defined as an "employer" in subsection (a) of this section shall be disregarded for purposes of determining the amount of taxes due pursuant to this chapter if the individual rendering such service has not previously rendered service, other than as such a delegate, which may be included in his "years of service" for purposes of the Railroad Retirement Act. Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "compensation" in regulations prescribed for purposes of this chapter.

* * * * * * *

(13) SPECIAL RULES FOR TAX ON EMPLOYERS ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For purposes of section 3221(c)—

(A) Paragraph (1) shall be applied without regard to the third sentence thereof.

(B) Paragraph (2) shall not apply.

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CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

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SEC. 3306. DEFINITIONS.

(a) * * *

(b) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) * * *

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee [or any of his dependents]*, any of his dependents, or any eligible beneficiary (within the meaning of section 106(f)) with respect to the employee,* under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*) or for a class or classes of his employees (or for a class or classes of his employees [and their dependents] *and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))*), on account of—

(A) sickness or accident disability (but, in the case of payments made to an employee [or any of his dependents]*, any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,*, this subparagraph shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or

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CHAPTER 24—COLLECTION OF INCOME TAX AT SOURCE ON WAGES

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SEC. 3401. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term "wages" means all remuneration (other than fees paid to a public official) for services performed by an employee for his employer, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include remuneration paid—

(1) * * *

* * * * * * *

(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d); [or]

(23) for any benefit or payment which is excludable from the gross income of the employee under section 139B(b)[.]*; or*

(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(f)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(f).

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Subtitle D—Miscellaneous Excise Taxes

CHAPTER 31—RETAIL EXCISE TAXES.

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[CHAPTER 34—POLICIES ISSUED BY FOREIGN INSURERS]

CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

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[CHAPTER 34—POLICIES ISSUED BY FOREIGN INSURERS]

CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

Subchapter A—Policies Issued By Foreign Insurers

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Subchapter B—Insured and Self-Insured Health Plans

Sec. 4375. Health insurance.
Sec. 4376. Self-insured health plans.
Sec. 4377. Definitions and special rules.

SEC. 4375. HEALTH INSURANCE.

(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

(1) IN GENERAL.—Except as otherwise provided in this section, the term "specified health insurance policy" means any accident or health insurance policy issued with respect to individuals residing in the United States.

(2) EXEMPTION FOR CERTAIN POLICIES.—The term "specified health insurance policy" does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

(i) such arrangement shall be treated as a specified health insurance policy, and

(ii) the person referred to in such subparagraph shall be treated as the issuer.

(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

SEC. 4376. SELF-INSURED HEALTH PLANS.

(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

(b) LIABILITY FOR FEE.—

(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

(2) PLAN SPONSOR.—For purposes of paragraph (1) the term "plan sponsor" means—

(A) the employer in the case of a plan established or maintained by a single employer,

(B) the employee organization in the case of a plan established or maintained by an employee organization,

(C) in the case of—

(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term "applicable self-insured health plan" means any plan for providing accident or health coverage if—

(1) any portion of such coverage is provided other than through an insurance policy, and

(2) such plan is established or maintained—

(A) by one or more employers for the benefit of their employees or former employees,

(B) by one or more employee organizations for the benefit of their members or former members,

(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

(E) by any organization described in section 501(c)(6), or

(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

SEC. 4377. DEFINITIONS AND SPECIAL RULES.

(a) DEFINITIONS.—For purposes of this subchapter—

(1) ACCIDENT AND HEALTH COVERAGE.—The term "accident and health coverage" means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

(2) INSURANCE POLICY.—The term "insurance policy" means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

(3) UNITED STATES.—The term "United States" includes any possession of the United States.

(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

(1) IN GENERAL.—For purposes of this subchapter—

(A) the term "person" includes any governmental entity, and

(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term "exempt governmental program" means—

(A) any insurance program established under title XVIII of the Social Security Act,

(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

(i) members of the Armed Forces of the United States, or

(ii) veterans, and

(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

Sec. 4971. Taxes on failure to meet minimum funding standards

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Sec. 4980H. Election with respect to health coverage participation requirements.

* * * * * * *

SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ELECTION OF EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.—

(1) IN GENERAL.—Subsection (b) shall apply to any employer with respect to whom an election under paragraph (2) is in effect.

(2) TIME AND MANNER.—An employer may make an election under this paragraph at such time and in such form and manner as the Secretary may prescribe.

(3) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414, the election under paragraph (2) shall be made by such person as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

(4) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under paragraph (2) with respect to—

(A) separate lines of business, and

(B) full-time employees and employees who are not full-time employees.

(5) TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary may terminate the election of any employer under paragraph (2) if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements.

(b) EXCISE TAX WITH RESPECT TO FAILURE TO MEET HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

(1) IN GENERAL.—In the case of any employer who fails (during any period with respect to which the election under subsection (a) is in effect) to satisfy the health coverage participation requirements with respect to any employee to whom such

election applies, there is hereby imposed on each such failure with respect to each such employee a tax of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

(2) LIMITATIONS ON AMOUNT OF TAX.—

(A) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by paragraph (1) on any failure during any period for which it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by paragraph (1) on any failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(C) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

(i) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for employment-based health plans, or

(ii) $500,000.

(D) COORDINATION WITH OTHER ENFORCEMENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure shall be reduced (but not below zero) by the amount of any civil penalty collected under section 502(c)(11) of the Employee Retirement Income Security Act of 1974 or section 2793(g) of the Public Health Service Act with respect to such failure.

(c) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this section, the term "health coverage participation requirements" means the requirements of part I of subtitle B of title III of the America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of this section).

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART II—TAX RETURNS OR STATEMENTS

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Subpart B—Income Tax Returns

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SEC. 6012. PERSONS REQUIRED TO MAKE RETURNS OF INCOME.

(a) GENERAL RULE.—Returns with respect to income taxes under subtitle A shall be made by the following:

(1) * * *

* * * * * * *

(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.

* * * * * * *

PART III—INFORMATION RETURNS

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Subpart B—Information Concerning Transactions With Other Persons

Sec. 6041. Information at source.

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Sec. 6050X. Returns relating to health insurance coverage.

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SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

(a) REQUIREMENT OF REPORTING.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

(1) is in such form as the Secretary may prescribe, and

(2) contains—

(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

(C) such other information as the Secretary may require.

(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

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Subchapter B—Miscellaneous Provisions

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SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) GENERAL RULE.—Returns and return information shall be confidential, and except as authorized by this title—

(1) * * *

* * * * * * *

(3) no other person (or officer or employee thereof) who has or had access to returns or return information under subsection (e)(1)(D)(iii), paragraph (6), (10), (12), (16), [(19),] or (20) of subsection (l), paragraph (2) or (4)(B) of subsection (m), or subsection (n),

* * * * * * *

(l) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

* * * * * * *

[(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

[(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services pursuant to carrying out section 1860D-31 of the Social Security Act, shall disclose to officers, employees, and contractors of the Department of Health and Human Services with respect to a taxpayer for the applicable year—

[(i)(I) whether the adjusted gross income, as modified in accordance with specifications of the Secretary of Health and Human Services for purposes of carrying out such section, of such taxpayer and, if applicable, such taxpayer's spouse, for the applicable year, exceeds the amounts specified by the Secretary of Health and Human Services in order to apply the 100 and 135 percent of the poverty lines under such sec-

tion, (II) whether the return was a joint return, and (III) the applicable year, or

[(ii) if applicable, the fact that there is no return filed for such taxpayer for the applicable year.

[(B) DEFINITION OF APPLICABLE YEAR.—For the purposes of this subsection, the term "applicable year" means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information systems, or, if there is no return filed for such taxpayer for such year, the prior taxable year.

[(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only for the purposes of determining eligibility for and administering transitional assistance under section 1860D-31 of the Social Security Act.]

(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION'S OUTREACH TO ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall be disclosed to officers and employees of the Social Security Administration, with respect to any taxpayer identified by the Commissioner of Social Security—

(i) return information for the applicable year from returns with respect to wages (as defined in section 3121(a) or 3401(a)) and payments of retirement income (as described in paragraph (1) of this subsection),

(ii) unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year,

(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self-employment, on such return,

(iv) if the individual is a married individual filing a separate return for the applicable year, the social security number (if reasonably available) of the spouse on such return,

(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, and subchapter S corporations of the individual's spouse on such return, and

(vi) such other return information relating to the individual (or the individual's spouse in the case of a joint return) as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act.

(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term "applicable year" means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer information records.

(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—

(i) individuals the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act and who have not applied for such subsidy, and

(ii) any individual the Social Security Administration has identified as a spouse of an individual described in clause (i).

(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only by officers and employees of the Social Security Administration solely for purposes of identifying individuals likely to be ineligible for a low-income prescription drug subsidy under section 1860D–14 of the Social Security Act for use in outreach efforts under section 1144 of the Social Security Act.

* * * * * * *

(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.—

(A) IN GENERAL.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 208 of the America's Affordable Health Choices Act of 2009, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009. Such return information shall be limited to—

(i) taxpayer identity information with respect to such taxpayer,

(ii) the filing status of such taxpayer,

(iii) the modified adjusted gross income of such taxpayer (as defined in section 59B(e)(5)),

(iv) the number of dependents of the taxpayer,

(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Ad-

ministration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title II of the America's Affordable Health Choices Act of 2009 and providing for the repayment of any such credit which was in excess of such appropriate amount.

* * * * * * *

(p) PROCEDURE AND RECORDKEEPING.—

(1) * * *

* * * * * * *

(4) SAFEGUARDS.—Any Federal agency described in subsection (h)(2), (h)(5), (i)(1), (2), (3), (5), or (7), (j)(1), (2), or (5), (k)(8) or (10), (l)(1), (2), (3), (5), (10), (11), (13), (14), [or (17)] *(17), or (19)* or (o)(1)(A), the Government Accountability Office, the Congressional Budget Office, or any agency, body, or commission described in subsection (d), (i)(3)(B)(i) or 7(A)(ii), or (l)(6), (7), (8), (9), (12), (15), or (16), any appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (l)(10), (16), (18), [(19),] or (20)*, or any entity described in subsection (l)(21),* shall, as a condition for receiving returns or return information—

(A) * * *

* * * * * * *

(F) upon completion of use of such returns or return information—

(i) in the case of an agency, body, or commission described in subsection (d), (i)(3)(B)(i), or (l)(6), (7), (8), (9), or (16), any appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (l)(10), (16), (18), [(19),] or (20) *or any entity described in subsection (l)(21),* return to the Secretary such returns or return information (along with any copies made therefrom) or make such returns or return information undisclosable in any manner and furnish a written report to the Secretary describing such manner,

(ii) in the case of an agency described in subsections (h)(2), (h)(5), (i)(1), (2), (3), (5) or (7), (j)(1), (2), or (5), (k)(8) or (10), (l)(1), (2), (3), (5), (10), (11), (12), (13), (14), (15), [or (17)] *(17), or (19)*, or (o)(1)(A), *or any entity described in subsection (l)(21),* the Government Accountability Office, or the Congressional Budget Office, either—

(I) * * *

* * * * * * *

except that the conditions of subparagraphs (A), (B), (C), (D), and (E) shall cease to apply with respect to any return or return information if, and to the extent that, such return or return information is disclosed in the course of any judicial or administrative proceeding and made a part of the public record thereof. If the Secretary determines that any such agency,

body, or commission, including an agency, an appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (l)(10), (16), (18), [(19),] or (20), *or any entity described in subsection (l)(21)*, or the Government Accountability Office or the Congressional Budget Office, has failed to, or does not, meet the requirements of this paragraph, he may, after any proceedings for review established under paragraph (7), take such actions as are necessary to ensure such requirements are met, including refusing to disclose returns or return information to such agency, body, or commission, including an agency, an appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (l)(10), (16), (18), [(19),] or (20) *or any entity described in subsection (l)(21),*, or the Government Accountability Office or the Congressional Budget Office, until he determines that such requirements have been or will be met. In the case of any agency which receives any mailing address under paragraph (2), (4), (6), or (7) of subsection (m) and which discloses any such mailing address to any agent or which receives any information under paragraph (6)(A), (10), (12)(B), or (16) of subsection (l) and which discloses any such information to any agent, or any person including an agent described in subsection (l)(10) or (16), this paragraph shall apply to such agency and each such agent or other person (except that, in the case of an agent, or any person including an agent described in subsection (l)(10) or (16), any report to the Secretary or other action with respect to the Secretary shall be made or taken through such agency). For purposes of applying this paragraph in any case to which subsection (m)(6) applies, the term "return information" includes related blood donor records (as defined in section 1141(h)(2) of the Social Security Act).

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CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

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Subchapter A—Additions to the Tax and Additional Amounts

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PART II—ACCURACY-RELATED AND FRAUD PENALTIES

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SEC. 6662. IMPOSITION OF ACCURACY-RELATED PENALTY ON UNDERPAYMENTS.

(a) * * *

(b) PORTION OF UNDERPAYMENT TO WHICH SECTION APPLIES.—This section shall apply to the portion of any underpayment which is attributable to 1 or more of the following:

(1) * * *

* * * * * * *

(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.

This section shall not apply to any portion of an underpayment on which a penalty is imposed under section 6663. Except as provided in paragraph (1) or (2)(B) of section 6662A(e), this section shall not apply to the portion of any underpayment which is attributable to a reportable transaction understatement on which a penalty is imposed under section 6662A.

* * * * * * *

(d) SUBSTANTIAL UNDERSTATEMENT OF INCOME TAX.—

(1) * * *

(2) UNDERSTATEMENT.—

(A) * * *

* * * * * * *

(C) REDUCTION NOT TO APPLY TO TAX SHELTERS.—

(i) IN GENERAL.—[Subparagraph (B)] *Subparagraphs (B) and (D)(i)(II)* shall not apply to any item attributable to a tax shelter.

* * * * * * *

(D) SPECIAL REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

(i) IN GENERAL.—In the case of any specified person—

(I) subparagraph (B) shall not apply, and

(II) the amount of the understatement under subparagraph (A) shall be reduced by that portion of the understatement which is attributable to any item with respect to which the taxpayer has a reasonable belief that the tax treatment of such item by the taxpayer is more likely than not the proper tax treatment of such item.

(ii) SPECIFIED PERSON.—For purposes of this subparagraph, the term "specified person" means—

(I) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

(II) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of subclause (II).

* * * * * * *

(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied

with respect to such portion by substituting "40 percent" for "20 percent".

(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term "nondisclosed noneconomic substance transaction" means any portion of a transaction described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.

SEC. 6662A. IMPOSITION OF ACCURACY-RELATED PENALTY ON UNDERSTATEMENTS WITH RESPECT TO REPORTABLE TRANSACTIONS.

(a) * * *

* * * * * * *

(e) SPECIAL RULES.—

(1) * * *

(2) COORDINATION WITH OTHER PENALTIES.—

(A) * * *

(B) COORDINATION WITH [GROSS VALUATION MISSTATEMENT PENALTY] *CERTAIN INCREASED UNDERPAYMENT PENALTIES*.—This section shall not apply to any portion of an understatement on which a penalty is imposed under section 6662 if the rate of the penalty is determined under [section 6662(h)] *subsections (h) or (i) of section 6662*.

* * * * * * *

SEC. 6664. DEFINITIONS AND SPECIAL RULES.

(a) * * *

* * * * * * *

(c) REASONABLE CAUSE EXCEPTION FOR UNDERPAYMENTS.—

(1) * * *

(2) EXCEPTION.—Paragraph (1) shall not apply to—

(A) to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6), and

(B) to any taxpayer if such taxpayer is a specified person (as defined in section 6662(d)(2)(D)(ii)).

[(2)] *(3)* SPECIAL RULE FOR CERTAIN VALUATION OVERSTATEMENTS.—In the case of any underpayment attributable to a substantial or gross valuation overstatement under chapter 1 with respect to charitable deduction property, paragraph (1) shall not apply. The preceding sentence shall not apply to a substantial valuation overstatement under chapter 1 if—

(A) * * *

* * * * * * *

[(3)] *(4)* DEFINITIONS.—For purposes of this subsection—

(A) CHARITABLE DEDUCTION PROPERTY.—The term "charitable deduction property" means any property contributed by the taxpayer in a contribution for which a deduction was claimed under section 170. For purposes of [paragraph (2)] *paragraph (3)*, such term shall not include any securities for which (as of the date of the contribution) market quotations are readily available on an established securities market.

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Subchapter B—Assessable Penalties

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PART I—GENERAL PROVISIONS

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SEC. 6676. ERRONEOUS CLAIM FOR REFUND OR CREDIT.

(a) * * *

* * * * * * *

(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.

[(c)] *(d)* COORDINATION WITH OTHER PENALTIES.—This section shall not apply to any portion of the excessive amount of a claim for refund or credit which is subject to a penalty imposed under part II of subchapter A of chapter 68.

* * * * * * *

PART II—FAILURE TO COMPLY WITH CERTAIN INFORMATION REPORTING REQUIREMENTS

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SEC. 6724. WAIVER; DEFINITIONS AND SPECIAL RULES.

(a) * * *

* * * * * * *

(d) DEFINITIONS.—For purposes of this part—

(1) INFORMATION RETURN.—The term "information return" means—

(A) * * *

(B) any return required by—

(i) * * *

* * * * * * *

(xxii) section 6039(a) (relating to returns required with respect to certain options), [or]

(xxiii) section 6050W (relating to returns to payments made in settlement of payment card transactions), [and] *or*

(xxiv) section 6050X (relating to returns relating to health insurance coverage), and

* * * * * * *

(2) PAYEE STATEMENT.—The term "payee statement" means any statement required to be furnished under—

(A) * * *

* * * * * * *

(EE) section 6050U (relating to charges or payments for qualified long-term care insurance contracts under combined arrangements), **[**or**]**

(FF) section 6050W(c) (relating to returns relating to payments made in settlement of payment card transactions)**[**.**]**, *or*

(GG) section 6050X (relating to returns relating to health insurance coverage).

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CHAPTER 75—CRIMES, OTHER OFFENSES, AND FORFEITURES

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Subchapter A—Crimes

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PART I—GENERAL PROVISIONS

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SEC. 7213. UNAUTHORIZED DISCLOSURE OF INFORMATION.

(a) RETURNS AND RETURN INFORMATION.—

(1) * * *

(2) STATE AND OTHER EMPLOYEES.—It shall be unlawful for any person (not described in paragraph (1)) willfully to disclose to any person, except as authorized in this title, any return or return information (as defined in section 6103(b)) acquired by him or another person under subsection (d), (i)(3)(B)(i) or (7)(A)(ii), (l)(6), (7), (8), (9), (10), (12), (15), (16), (19), **[**or (20)**]** *(20), or (21)* or (m)(2), (4), (5), (6), or (7) of section 6103 or under section 6104(c). Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.

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CHAPTER 79—DEFINITIONS

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SEC. 7701. DEFINITIONS.

(a) * * *

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(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) ECONOMIC SUBSTANCE DOCTRINE.—The term "economic substance doctrine" means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of

transactions) shall be made in the same manner as if this subsection had never been enacted.

(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.

[(o)] *(p)* CROSS REFERENCES.—

(1) * * *

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Subtitle I—Trust Fund Code

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CHAPTER 98 TRUST FUND CODE

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Subchapter A—Establishment of Trust Funds

Sec. 9501. Black Lung Disability Trust Fund.

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Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.

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SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the "Health Care Comparative Effectiveness Research Trust Fund" (hereinafter in this section referred to as the "CERTF"), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

(1) For fiscal year 2010, $90,000,000.

(2) For fiscal year 2011, $100,000,000.

(3) For fiscal year 2012, $110,000,000.

(4) For each fiscal year beginning with fiscal year 2013—

(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in

proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

(c) FAIR SHARE PER CAPITA AMOUNT.—

(1) COMPUTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2013) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

(B) ALTERNATIVE COMPUTATION.—

(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

(ii) DEFAULT AMOUNT.—The default amount under this clause for—

(I) fiscal year 2013 is equal to $2; or

(II) a subsequent year is equal to the default amount under this clause for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

(d) EXPENDITURES FROM FUND.—

(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and Human Services for carrying out section 1181 of the Social Security Act.

(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1181(b) of the Social Security Act for such fiscal year:

(A) For fiscal year 2010, $7,000,000.

(B) For fiscal year 2011, $9,000,000.

(C) For each fiscal year beginning with 2012, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

(e) NET REVENUES.—For purposes of this section, the term "net revenues" means the amount estimated by the Secretary based on the excess of—

(1) the fees received in the Treasury under subchapter B of chapter 34, over

(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

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AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

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DIVISION B—TAX, UNEMPLOYMENT, HEALTH, STATE FISCAL RELIEF, AND OTHER PROVISIONS

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TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS

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Subtitle C—Miscellaneous Medicare Provisions

SEC. 4301. MORATORIA ON CERTAIN MEDICARE REGULATIONS.

(a) DELAY IN PHASE OUT OF MEDICARE HOSPICE BUDGET NEUTRALITY ADJUSTMENT FACTOR DURING FISCAL YEAR 2009.—Notwithstanding any other provision of law, including the final rule published on August 8, 2008, 73 Federal Register 46464 et seq., relating to Medicare Program; Hospice Wage Index for Fiscal Year 2009, the Secretary of Health and Human Services shall not phase out or eliminate the budget neutrality adjustment factor in the Medicare hospice wage index before [October 1, 2009] *October 1, 2010*, and the Secretary shall recompute and apply the final Medicare hospice wage index [for fiscal year 2009] *for fiscal years 2009 and 2010* as if there had been no reduction in the budget neutrality adjustment factor.

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SECTION 4505 OF THE BALANCED BUDGET ACT OF 1997

SEC. 4505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.

(a) * * *

* * * * * * *

[(d) REQUIREMENTS FOR DEVELOPING NEW RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—

[(1) DEVELOPMENT.—For purposes of section 1848(c)(2)(C)(ii) of the Social Security Act, the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units the Secretary shall—

[(A) utilize, to the maximum extent practicable, generally accepted cost accounting principles which (i) recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures, and (ii) use actual data on equipment utilization and other key assumptions;

[(B) consult with organizations representing physicians regarding methodology and data to be used; and

[(C) develop a refinement process to be used during each of the 4 years of the transition period.

[(2) REPORT.—The Secretary shall transmit a report by March 1, 1998, on the development of resource-based relative value units under paragraph (1) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data to be used in developing the value units and an explanation of the methodology.

[(3) NOTICE OF PROPOSED RULEMAKING.—The Secretary shall publish a notice of proposed rulemaking with the new resource-based relative value units on or before May 1, 1998, and shall allow for a 90-day public comment period.

[(4) ITEMS INCLUDED.—The new proposed rule shall consider the following:

[(A) Impact projections which compare new proposed payment amounts on data on actual physician practice expenses.

[(B) Impact projections for hospital-based and other specialties, geographic payment localities, and urban versus rural localities.]

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TAX RELIEF AND HEALTH CARE ACT OF 2006

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DIVISION B—MEDICARE AND OTHER HEALTH PROVISIONS

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TITLE I—MEDICARE IMPROVED QUALITY AND PROVIDER PAYMENTS

* * * * * * *

SEC. 106. HOSPITAL MEDICARE REPORTS AND CLARIFICATIONS.

(a) CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION.—Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through [September 30, 2009] *September 30, 2011*. The previous sentence shall not be effected in a budget-neutral manner.

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TITLE II—MEDICARE BENEFICIARY PROTECTIONS

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[SEC. 204. MEDICARE MEDICAL HOME DEMONSTRATION PROJECT.

[(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish under title XVIII of the Social Security Act a medical home demonstration project (in this section referred to as the "project") to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which—

[(1) care management fees are paid to persons performing services as personal physicians; and

[(2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

For purposes of this subsection, the term "high-need population" means individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.

[(b) DETAILS.—

[(1) DURATION; SCOPE.—Subject to paragraph (3), the project shall operate during a period of three years and shall include urban, rural, and underserved areas in a total of no more than 8 States.

[(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—The project shall be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

[(3) EXPANSION.—The Secretary may expand the duration and the scope of the project under paragraph (1), to an extent determined appropriate by the Secretary, if the Secretary determines that such expansion will result in any of the following conditions being met:

[(A) The expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program (not taking into account amounts available under subsection (g)).

[(B) The expansion of the project is expected to reduce spending under the Medicare program (not taking into account amounts available under subsection (g)) without reducing the quality of patient care.

[(c) PERSONAL PHYSICIAN DEFINED.—

[(1) IN GENERAL.—For purposes of this section, the term "personal physician" means a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)) who—

[(A) meets the requirements described in paragraph (2); and

[(B) performs the services described in paragraph (3).

Nothing in this paragraph shall be construed as preventing such a physician from being a specialist or subspecialist for an individual requiring ongoing care for a specific chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for an individual with a prolonged illness.

[(2) REQUIREMENTS.—The requirements described in this paragraph for a personal physician are as follows:

[(A) The physician is a board certified physician who provides first contact and continuous care for individuals under the physician's care.

[(B) The physician has the staff and resources to manage the comprehensive and coordinated health care of each such individual.

[(3) SERVICES PERFORMED.—A personal physician shall perform or provide for the performance of at least the following services:

[(A) Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies).

[(B) Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

[(C) Uses health information technology, that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

[(D) Encourages patients to engage in the management of their own health through education and support systems.

[(d) MEDICAL HOME DEFINED.—For purposes of this section, the term "medical home" means a physician practice that—

[(1) is in charge of targeting beneficiaries for participation in the project; and

[(2) is responsible for—

[(A) providing safe and secure technology to promote patient access to personal health information;

[(B) developing a health assessment tool for the individuals targeted; and

[(C) providing training programs for personnel involved in the coordination of care.

[(e) PAYMENT MECHANISMS.—

[(1) PERSONAL PHYSICIAN CARE MANAGEMENT FEE.—Under the project, the Secretary shall provide for payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) of a care management fee to personal physicians providing care management under the project. Under such section and using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code.

[(2) MEDICAL HOME SHARING IN SAVINGS.—The Secretary shall provide for payment under the project of a medical home based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act (42 U.S.C. 1395cc–1). Under such methodology, 80 percent of the reductions in expenditures under title XVIII of the Social Security Act resulting from participation of individuals that are attributable to the medical home (as reduced by the total care managements fees paid to the medical home under the project) shall be paid to the medical home. The amount of such reductions in expenditures shall be determined by using assumptions with respect to reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions.

[(3) SOURCE.—Payments paid under the project shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

[(f) EVALUATIONS AND REPORTS.—

[(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

[(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the project and shall submit to Congress, not later than one year after completion of the project, a report on the project and on the evaluation of the project.

[(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

[(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.]

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SECTION 542 OF THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000

SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

(a) * * *

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(c) EFFECTIVE DATE.—This section shall apply to services furnished during the 2-year period beginning on January 1, 2001, and for services furnished during 2005, 2006, 2007, 2008, [and 2009] *2009, 2010, and 2011*.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008

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TITLE I—MEDICARE

* * * * * * *

Subtitle C—Provisions Relating to Part B

PART I—PHYSICIANS' SERVICES

* * * * * * *

SEC. 138. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the period beginning on July 1, 2008, and ending on [December 31, 2009] *December 31, 2011*, the Secretary of Health and Human Services shall increase the fee schedule otherwise applicable for specified services by 5 percent.

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PART II—OTHER PAYMENT AND COVERAGE IMPROVEMENTS

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SEC. 146. IMPROVED ACCESS TO AMBULANCE SERVICES.

(a) * * *

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(b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

(1) TREATMENT OF CERTAIN AREAS FOR PAYMENT FOR AIR AMBULANCE SERVICES UNDER THE AMBULANCE FEE SCHEDULE.—Notwithstanding any other provision of law, for purposes of making payments under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for air ambulance services furnished during the period beginning on July 1, 2008, and [ending on

December 31, 2009] *ending on December 31, 2011*, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished during such period.

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MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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TITLE IV—RURAL PROVISIONS

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Subtitle C—Provisions Relating to Parts A and B

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SEC. 422. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) * * *

(b) CONFORMING PROVISIONS.—(1) * * *

(2) Chapter 35 of title 44, United States Code, shall not apply with respect to applications under [section 1886(h)(7) of the Social Security Act, as added by subsection (a)(3).] *paragraphs (4)(H)(vi), (7), and (8) of subsection (h) of section 1886 of the Social Security Act.*

* * * * * * *

TITLE VIII—COST CONTAINMENT

[Subtitle A—Cost Containment

[SEC. 801. INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS.

[(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

[(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

[(A) the information described in subsection (b); and

[(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

[(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle, an af-

firmative determination under paragraph (1)(B) in 2 consecutive annual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

[(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term "7-fiscal-year reporting period" means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

[(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

[(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

[(A) Each fiscal year within the 7-fiscal-year reporting period.

[(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

[(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

[(A) The gross domestic product.

[(B) Private health costs.

[(C) National health expenditures.

[(D) Other appropriate measures.

[(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act, as added by section 101.

[(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

[(c) DEFINITIONS.—For purposes of this section:

[(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term "excess general revenue medicare funding" means, with respect to a fiscal year, that—

[(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

[(B) 45 percent.

[(2) GENERAL REVENUE MEDICARE FUNDING.—The term "general revenue medicare funding" means for a year—

[(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

[(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

[(3) DEDICATED MEDICARE FINANCING SOURCES.—The term "dedicated medicare financing sources" means the following:

[(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

[(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21), as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66).

[(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act.

[(D) PREMIUMS.—The following premiums:

[(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

[(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

[(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act, as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title, as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D–13(b) of such title, as added by section 101.

[(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

[(4) TOTAL MEDICARE OUTLAYS.—The term "total medicare outlays" means total outlays from the medicare trust funds and shall—

[(A) include payments made to plans under part C of title XVIII of the Social Security Act that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1);

[(B) include administrative expenditures made in carrying out title XVIII of such Act and Federal outlays under section 1935(b) of such Act, as added by section 103(a)(2); and

[(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

[(5) MEDICARE TRUST FUND.—The term "medicare trust fund" means—

[(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

[(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42

U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

[(d) CONFORMING AMENDMENTS.—

[(1) FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817(b)(2) (42 U.S.C. 1395i(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

[(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(b)(2) (42 U.S.C. 1395t(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

[(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.

[SEC. 802. PRESIDENTIAL SUBMISSION OF LEGISLATION.

[(a) IN GENERAL.—Section 1105 of title 31, United States Code, is amended by adding at the end the following new subsection:

["(h)(1) If there is a medicare funding warning under section 801(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under subsection (a) for the succeeding year, proposed legislation to respond to such warning.

["(2) Paragraph (1) does not apply if, during the year in which the warning is made, legislation is enacted which eliminates excess general revenue medicare funding (as defined in section 801(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) for the 7-fiscal-year reporting period, as certified by the Board of Trustees of each medicare trust fund (as defined in section 801(c)(5) of such Act) not later than 30 days after the date of the enactment of such legislation.".

[(b) SENSE OF CONGRESS.—It is the sense of Congress that legislation submitted pursuant to section 1105(h) of title 31, United States Code, in a year should be designed to eliminate excess general revenue medicare funding (as defined in section 801(c)) for the 7-fiscal-year period that begins in such year.

[SEC. 803. PROCEDURES IN THE HOUSE OF REPRESENTATIVES.

[(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

[(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader of the House of Representatives (or his designee) and the Minority Leader of the House of Representatives (or his designee) shall introduce such proposal (by request), the title of which is as follows: "A

bill to respond to a medicare funding warning." Such bill shall be introduced within 3 legislative days after Congress receives such proposal.

[(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives.

[(b) DIRECTION TO THE APPROPRIATE HOUSE COMMITTEES.—

[(1) IN GENERAL.—In the House, in any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, the appropriate committees shall report medicare funding legislation by not later than June 30 of such year.

[(2) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

[(A) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

[(B) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

[(3) CERTIFICATION.—With respect to any medicare funding legislation or any amendment to such legislation to respond to a medicare funding warning, the chairman of the Committee on the Budget of the House shall certify—

[(A) whether or not such legislation eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period; and

[(B) with respect to such an amendment, whether the legislation, as amended, would eliminate excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in such 7-fiscal-year reporting period.

[(c) FALLBACK PROCEDURE FOR FLOOR CONSIDERATION IF THE HOUSE FAILS TO VOTE ON FINAL PASSAGE BY JULY 30.—

[(1) After July 30 of any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, unless the House of Representatives has voted on final passage of any medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A), then, after the expiration of not less than 30 calendar days (and concurrently 5 legislative days), it is in order to move to discharge any committee to which medicare funding legislation which has such a certification and which has been referred to such committee for 30 calendar days from further consideration of the legislation.

[(2) A motion to discharge may be made only by an individual favoring the legislation, may be made only if supported by one-fifth of the total membership of the House (a quorum being present), and is highly privileged in the House. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between those favoring and those opposing the motion. An amendment to the motion is not in order, and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

[(3) Only one motion to discharge a particular committee may be adopted under this subsection in any session of a Congress.

[(4) Notwithstanding paragraph (1), it shall not be in order to move to discharge a committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if, during the previous session of the Congress, the House passed medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A).

[(d) FLOOR CONSIDERATION IN THE HOUSE OF DISCHARGED LEGISLATION.—

[(1) In the House, not later than 3 legislative days after any committee has been discharged from further consideration of legislation under subsection (c), the Speaker shall resolve the House into the Committee of the Whole for consideration of the legislation.

[(2) The first reading of the legislation shall be dispensed with. All points of order against consideration of the legislation are waived. General debate shall be confined to the legislation and shall not exceed five hours, which shall be divided equally between those favoring and those opposing the legislation. After general debate the legislation shall be considered for amendment under the five-minute rule. During consideration of the legislation, no amendments shall be in order in the House or in the Committee of the Whole except those for which there has been an affirmative certification under subsection (b)(3)(B). All points of order against consideration of any such amendment in the Committee of the Whole are waived. The legislation, together with any amendments which shall be in order, shall be considered as read. During the consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of Rule XVIII of the Rules of the House of Representatives. Debate on any amendment shall not exceed one hour, which shall be divided equally between those favoring and those opposing the amendment, and no pro forma amendments shall be offered during the debate. The total time for debate on all amendments shall not exceed 10 hours. At the conclusion of consideration of the legislation for amendment, the Committee shall rise and report the legislation to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the legislation and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of Rule XIV of the Rules of the House of Representatives, resolve into the Committee of the Whole for further consideration of the bill.

[(3) All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to

the procedure relating to any such legislation shall be decided without debate.

[(4) Except to the extent specifically provided in the preceding provisions of this subsection, consideration of any such legislation and amendments thereto (or any conference report thereon) shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions, amendments, and conference reports in similar circumstances.

[(e) LEGISLATIVE DAY DEFINED.—As used in this section, the term "legislative day" means a day on which the House of Representatives is in session.

[(f) RESTRICTION ON WAIVER.—In the House, the provisions of this section may be waived only by a rule or order proposing only to waive such provisions.

[(g) RULEMAKING POWER.—The provisions of this section are enacted by the Congress—

[(1) as an exercise of the rulemaking power of the House of Representatives and, as such, shall be considered as part of the rules of that House and shall supersede other rules only to the extent that they are inconsistent therewith; and

[(2) with full recognition of the constitutional right of that House to change the rules (so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

[SEC. 804. PROCEDURES IN THE SENATE.

[(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

[(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader and Minority Leader of the Senate (or their designees) shall introduce such proposal (by request), the title of which is as follows: "A bill to respond to a medicare funding warning." Such bill shall be introduced within 3 days of session after Congress receives such proposal.

[(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the Committee on Finance.

[(b) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

[(1) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

[(2) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

[(c) QUALIFICATION FOR SPECIAL PROCEDURES.—

[(1) IN GENERAL.—The special procedures set forth in subsections (d) and (e) shall apply to medicare funding legislation, as described in subsection (b), only if the legislation—

[(A) is medicare funding legislation that is passed by the House of Representatives; or

[(B) contains matter within the jurisdiction of the Committee on Finance in the Senate.

[(2) FAILURE TO QUALIFY FOR SPECIAL PROCEDURES.—If the medicare funding legislation does not satisfy paragraph (1), then the legislation shall be considered under the ordinary procedures of the Standing Rules of the Senate.

[(d) DISCHARGE.—

[(1) IN GENERAL.—If the Committee on Finance has not reported medicare funding legislation described in subsection (c)(1) by June 30 of a year in which the President is required to submit medicare funding legislation to Congress under section 1105(h) of title 31, United States Code, then any Senator may move to discharge the Committee of any single medicare funding legislation measure. Only one such motion shall be in order in any session of Congress.

[(2) DEBATE LIMITS.—Debate in the Senate on any such motion to discharge, and all appeals in connection therewith, shall be limited to not more than 2 hours. The time shall be equally divided between, and controlled by, the maker of the motion and the Majority Leader, or their designees, except that in the event the Majority Leader is in favor of such motion, the time in opposition thereto shall be controlled by the Minority Leader or the Minority Leader's designee. A point of order under this subsection may be made at any time. It is not in order to move to proceed to another measure or matter while such motion (or the motion to reconsider such motion) is pending.

[(3) AMENDMENTS.—No amendment to the motion to discharge shall be in order.

[(4) EXCEPTION IF CERTIFIED LEGISLATION ENACTED.—Notwithstanding paragraph (1), it shall not be in order to discharge the Committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if the chairman of the Committee on the Budget of the Senate certifies that medicare funding legislation has been enacted that eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period.

[(e) CONSIDERATION.—After the date on which the Committee on Finance has reported medicare funding legislation described in subsection (c)(1), or has been discharged (under subsection (d)) from further consideration of, such legislation, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the Senate to move to proceed to the consideration of such legislation.

[(f) RULES OF THE SENATE.—This section is enacted by the Senate—

[(1) as an exercise of the rulemaking power of the Senate and as such it is deemed a part of the rules of the Senate, but applicable only with respect to the procedure to be followed in the Senate in the case of a bill described in this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

[(2) with full recognition of the constitutional right of the Senate to change the rules (so far as relating to the procedure

of the Senate) at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.]

* * * * * * *

SECTION 5007 OF THE DEFICIT REDUCTION ACT OF 2005

SEC. 5007. MEDICARE DEMONSTRATION PROJECTS TO PERMIT GAINSHARING ARRANGEMENTS.

(a) * * *

* * * * * * *

(d) PROGRAM ADMINISTRATION.—

(1) * * *

* * * * * * *

(3) DURATION.—The qualified gainsharing demonstration program under this section shall be conducted for the period beginning on January 1, 2007, and ending on December 31, 2009 *(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)*.

(e) REPORTS.—

(1) * * *

* * * * * * *

(3) QUALITY IMPROVEMENT AND SAVINGS.—By not later than [December 1, 2008] *March 31, 2011*, the Secretary shall submit to Congress a report on quality improvement and savings achieved as a result of the qualified gainsharing demonstration program established under subsection (a).

(4) FINAL REPORT.—By not later than [May 1, 2010] *March 31, 2013*, the Secretary shall submit to Congress a final report on the information described in paragraph (3).

(f) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006 $6,000,000, *and for fiscal year 2010, $1,600,000,* to carry out this section.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year [2010] *2014 or until expended*.

* * * * * * *

VII. DISSENTING VIEWS

DISSENTING VIEWS

OVERVIEW

H.R. 3200 is fundamentally flawed legislation that threatens to simultaneously do irreparable harm to the health delivery system and add mountains of additional debt on our children and grandchildren. Long before those bills come due, though, Americans with health insurance would pay thousands of dollars more per year for coverage, and a host of new taxes on individuals and businesses would further hamper efforts to revive an already struggling economy if this bill becomes law.

The bill violates oft-repeated promises by the President and others that health care reform won't cause people to lose coverage they like, that taxes won't increase on families with income less than $250,000 and that tax rates won't increase above what they were during the 1990s.

The minority was united in opposition to the bill for five main reasons:

1. It was unnecessarily rushed through the Committee without proper understanding or even a reading of the bill by Members;
2. The massive spending and tax increases will damage an already reeling economy;
3. Americans will lose coverage they have and like;
4. The bill gives the government control over Americans' personal health decisions; and
5. Numerous specific improvements we proposed to the bill were all rejected.

I. BILL SHOULD NOT HAVE BEEN RUSHED INTO AND OUT OF COMMITTEE

While we share the majority's goal of improving the nation's health care system, the issues are too important and the decisions too difficult to act in haste and without the full range of information necessary to make such critical policy choices.

We held only one hearing on the discussion draft released in June, however not one of the witnesses spoke knowledgably about all of the provisions in the bill because they were only given a couple of days to digest it.

The measure approved by the Committee was substantially changed from the June draft, with the last round of edits coming out just after midnight on Thursday, July 16th, a few hours before the one-day markup of the legislation that began at 9 a.m. that morning.

This contrasts starkly with the health care reform debate in 1994. That year, the full Ways and Means Committee spent 17 days over six weeks conducting our markup. And that was only after holding a dozen hearings (eight at Subcommittee, four at full Committee) on the bill after its introduction.

It is also worth pointing out that the Committee refused to act on the Clinton bill in 1994 until nearly three months after the Congressional Budget Office (CBO) released a comprehensive, 104-page analysis and score. We had no such analysis of H.R. 3200 or the Chairman's mark. What we had instead was a very rough estimate on only a portion of the bill based on specifications as outlined by the Majority to CBO, not on actual legislative text. As Director Elmendorf wrote to Chairman Rangel:

"It is important to note, however, that [those] estimates are based on specifications provided by the tri-committee group rather than an analysis of the language released [this week]. For that reason and others outlined below, those figures do not represent a formal or complete cost estimate for the coverage provisions of the draft legislation."

Quite simply, that is not adequate for a bill as important as this, one that will have such far-reaching impacts on every family and business in America. We cannot afford to guess and hope we got it right. This Committee had no business marking up a bill of which CBO cannot tell us its cost or impacts. That view was further confirmed by testimony during the day by Director Elmendorf about the long-term budget impact of this legislation.

II. MASSIVE SPENDING AND TAX INCREASES WILL HURT ECONOMY

What we do know about the bill is that it matches more than a trillion dollars in new spending that grows even faster than the revenues being generated to pay for it, creating a massive, long-term unfunded federal mandate that imperils the fiscal future of this nation. Ironically, despite claims that the United States is already "spending too much on health care," the bill finances even higher spending with more than $820 billion in new taxes that will be paid for by families making as little as $20,000, small businesses, and manufacturers—all while we are in the midst of a recession and with unemployment moving quickly toward 10 percent.

Section 412 of the bill includes a mandate that employers provide health coverage deemed acceptable by the Federal Government or else pay a new payroll tax of eight percent of total payroll (a so-called "pay-or-play" scheme) that will bring the total U.S. federal payroll tax to more than 23 percent. Only the smallest of businesses would get any relief from this job-killing tax. Economists across the political spectrum agree that workers suffer the economic burden of payroll taxes. In a July 13, 2009 report entitled, "Effects of Changes to the Health Insurance System on Labor Markets," the Congressional Budget Office concluded that an employer mandate "is likely to reduce employment," with the effect being most severe for low-wage workers. It is therefore disappointing that the Majority chose to ignore the warnings of leading groups representing businesses in America about the damage this will do to employment and wages in America.

Section 441 of the bill attempts to plug part of the fiscal hole it creates with a new surtax on individuals and small businesses. The 5.4-percent surtax rate, combined with the already scheduled increase in the top marginal rate to 39.6 percent, would result in an increase in the top Federal income tax rate from 35 percent in 2010 to 45 percent in 2011. Adding in the 2.9-percent Medicare payroll tax and hidden marginal rate increases that operate by phasing out certain deductions, the proposed top Federal rate would jump to about 48 percent, and the average top Federal-State marginal tax rate would be over 52 percent.

While nominally aimed at individuals, the surtax will fall heavily on small businesses, the engine of job creation. According to a Joint Committee on Taxation data projection for 2011, 42 percent of small business income (including the income of sole proprietorships, partnerships, and S Corporations) would be subject to the surtax.

Not content to just tax "the wealthy," the bill also imposes large taxes on some of America's poorest families. Effective in 2013, section 401 would impose a tax on individuals without "acceptable coverage", which would hit single filers with incomes as low as $9,350 and married couples with incomes as low as $18,700 (in 2009 dollars). This undermines President Obama's ongoing promise not to raise taxes on families with incomes under $250,000.

Section 442 would prohibit the use of tax-free distributions from Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs) to purchase medicine or drugs other than prescription drugs or insulin. By imposing this restriction on the estimated 47 to 50 million individuals who currently carry coverage that includes either an HSA, FSA, or HRA, the bill violates another of President Obama's pledges: to allow families to keep the coverage they have and like.

In addition, the Majority would impose several unwise tax increases that bear no relationship to the purpose of the legislation other than to fund the move toward nationalization of health care in this country. These tax increases include a provision that appears to violate our tax treaties with our trading partners; a multi-year delay in rules that would allow worldwide American businesses to calculate their interest expense more accurately; and codification of the economic substance doctrine. The delay of the interest expense allocation rules is especially troubling. By terminating this tax increase at the end of the budget window, the Majority seems to be subtly acknowledging that the revenues generated by the bill will further fail to keep pace with its spending in the long-run.

III. AMERICANS WILL LOSE THE COVERAGE THEY HAVE AND LIKE

Independent analysis demonstrates that under H.R. 3200, two out of three Americans will lose the coverage they currently enjoy because it establishes a government-run health plan. It will, over time, force other coverage out of the market, eventually turning the government option into a federal monopoly.

This starts with the creation of a federally subsidized government-run insurance plan that would pay hospitals and doctors at set Medicare rates for services. As Medicare significantly under-

pays providers, the government-run plan will force private plans to pick up the slack. As a result, the average cost of private coverage for a family of four would be $3,628 more expensive because of the new and existing cost-shift, according to analysis by Milliman and the Lewin Group. Because it is unlikely that providers will willingly accept the government-run plan's low reimbursements, the Secretary of HHS would have the authority to force providers to participate in this plan.

The government-run plan will not have to pay state or federal taxes. It would be exempt from complying with state benefit and provider mandates, which have been shown to increase the cost of health insurance. The plan provides a $2 billion interest free loan from taxpayers. Unlike private insurance plans, who can be sued in state courts, the government-run plan could only be sued in federal court. And finally it will have the full backing of the United States government. Regardless of any assurances to the contrary, the government-run insurance plan will be "too big to fail," almost ensuring that taxpayers will be responsible for any funding shortfalls. This affords the government plan further significant advantage over the plans it is supposed to "compete" against.

To further guarantee that result, all private health plans would be required to conform to benefit mandates, as determined by the federal government. Any employer offering coverage that wasn't approved by the government would be forced to pay a steep tax penalty. Further, individual market plans would be prohibited from enrolling new members and would be prohibited from updating their benefits or cost-sharing arrangements for those currently enrolled. This prohibition on new enrollment will result in a death spiral where insurance costs for a plan climb at an unsustainable rate for all existing health insurance plans. By guaranteeing adverse selection will occur, the bill will ultimately force these plans to close down completely.

The bill further prohibits any new insurance plan from creating health coverage that does not conform to the federal government's requirements, and that insurance plan will not be allowed to exist outside of the government established super-structure, referred to in H.R. 3200 as the Exchange. By prohibiting new insurance plans that don't comply with various new federal requirements, the bill effectively limits choice in the insurance market.

IV. GIVES THE GOVERNMENT CONTROL OVER PERSONAL HEALTH CARE DECISIONS

H.R. 3200 will create a system by which health care decisions will be made in Washington that should be made in doctor's offices by patients and their physicians and at kitchen tables by families. House Democrats would establish a new government-run "Exchange" run by a new "Health Choices Commissioner" nominated by the President and confirmed by the Senate. As the Commissioner is serving at the pleasure of the President, some may be concerned about the lack of independence of this individual. The Commissioner would also be required to work with the Secretary of Health and Human Services, who oversees the government-run insurance plan described above, creating the potential for a serious

conflict of interest that could significantly disadvantage the private coverage that insures more than 170 million Americans today.

Aside from the will of the President, the Commissioner's power would be unchecked. This is extremely troubling given the large scope of responsibility given to the Commissioner. In fact, the Commissioner is so powerful that the title is referenced almost 200 times in H.R. 3200. This government official would have:

- The power to decide which treatments patients could receive and at what cost;
- The power to decide which private plans would be allowed to participate in the Exchange;
- The power to regulate all insurance plans, both in and out of the Exchange;
- The power to determine which employers would be allowed to participate in the Exchange;
- The power to determine how many Americans will be allowed to choose health coverage through the Exchange;
- The power to form and control which physicians and hospitals participate in the government-run plan and in private plan provider networks;
- The power to determine which states are allowed to operate their own Exchange and terminate a previously-approved State Exchange at any time;
- The power to override state laws regarding covered health benefits;
- The power to determine how trillions of taxpayer and employer dollars would be spent within the Exchange;
- The power to determine who qualifies for premium assistance; and
- The power to automatically enroll Americans into the Exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan.

Also troubling is the fact the Secretary of Health and Human Services would decide which prescription drugs are made available in the government plan. Evidence has shown that government officials in other countries have used this power to deny access to needed treatments on the basis of cost.

The bill also contains a new initiative on Comparative Effectiveness Research (CER). This board and its research will significantly harm the patient-doctor relationship if government-run health care uses the research to restrict treatments deemed too expensive. The bill reported by the Committee contains a provision expressly prohibiting the CER board from using its research to make coverage determinations. That may be the biggest of many fig leaves in the bill; in this case, the joke is on us, since the CER board would never make a coverage determination—it doesn't issue health insurance or pay claims, or have to decide what is covered and what is not.

But those who would make such coverage decisions, like the Centers for Medicare and Medicaid Services (CMS), face no such restrictions on their use of CER data. Peter Orszag, Director of the Office of Management and Budget, has publicly affirmed the Administration's desire to use CER to "bend the cost curve." As it relates to CER, this means that CMS and the Health Choices Com-

missioner will be able to deny coverage based on the cost of treatment, or ration access to health care services, for people in Medicare and every American enrolled in insurance plans offered through the Exchange.

V. ATTEMPTS TO IMPROVE THE LEGISLATION WERE REJECTED

Sadly, the foregoing does not constitute a complete review of the flaws of this legislation. During the Committee mark-up, these and other concerns were identified. Republicans attempted to address them through more than three dozen amendments. Those included amendments to: eliminate the government-run health insurance plan that could result in two out of three Americans losing their current coverage; ensure that comparative effectiveness research isn't used to ration care based on cost; terminate the government-run plan if wait times for care become too long; prevent the government from requiring health care providers to serve patients enrolled in the government-run health plan; ensure the Health Choices Commissioner could not deem abortion to be a required benefit; reverse cuts to Medicare Advantage plans, which give seniors access to benefits not found in the government-run Medicare program; and promote medical liability reform, which would help address the impact that the practice of defensive medicine has on health care spending.

Sadly, not a single one of these or the other amendments offered was accepted, reinforcing the widely held belief that this effort is a purely partisan exercise in which additional views and suggestions simply are not welcome.

CONCLUSION

At the outset of the mark-up, the Majority rejected a motion by the Ranking Member to delay consideration of the bill by one week, notwithstanding the fact the bill had been available for only a few hours and that the Committee did not even have a Congressional Budget Office estimate about the short and long-term impact of the package.

We suppose that should have been an indication about what was to come and the futility of trying to improve this deeply flawed product.

Hours after the mark-up ended, the Congressional Budget Office did release a further partial score of the bill (still based on descriptions of what is in the bill rather than on the legislative text itself). The overall conclusion is that the bill adds nearly $240 billion to the deficit this decade, with the bulk of those costs occurring at the end of the budget window. In 2015 alone, the bill will add $40 billion to the federal deficit. By 2019, that figure will rise to $65 billion and the deepening debt impact shows no signs of slowing down in future years. In short, the $240 billion that this adds to the deficit this decade is just the tip of the fiscal iceberg.

We would like to hope that the Majority's mad dash for an arbitrary finish line, regardless of the consequences, will be called off before real and lasting damage is done to our health care system and our economy. But as we write this, the prognosis is not good.

DAVE CAMP, Michigan,

WALLY HERGER, California,
SAM JOHNSON, Texas,
KEVIN BRADY, Texas,
PAUL RYAN, Wisconsin,
ERIC CANTOR, Virginia,
JOHN LINDER, Georgia,
DEVIN NUNES, California,
PATRICK J. TIBERI, Ohio,
GINNY BROWN-WAITE, Florida,
GEOFF DAVIS, Kentucky,
DAVID G. REICHERT, Washington,
CHARLES W. BOUSTANY, JR., Louisiana,
DEAN HELLER, Nevada,
PETER J. ROSKAM, Illinois.

VIII. ADDITIONAL VIEWS

RESTRICTS CURRENT PHYSICIAN OWNED HOSPITALS, PROHIBITS ONES UNDER CONSTRUCTION

Section 1156 of H.R. 3200 contains provisions that would devastate physician-owned hospitals across this country in two ways. First, it contains a retroactive effective date. Section 1156 states that in order for a physician-owned facility to have the ability to bill Medicare for services, it needs to have received a Medicare provider number by January 1, 2009, a date that came and went over 6 months ago.

This language would prevent 104 hospitals that are under development in over 20 states from ever receiving their Medicare provider number. This includes hospitals that have opened their doors and are already seeing patients, but have not received a provider number through no fault of their own. This means that hospitals, which were relying on current law, would be prohibited from ever becoming a Medicare provider, because of some arbitrary and retroactive deadline set forth in this legislation. Over $5 billion of investments have been made towards these 104 projects; this provision threatens not only those investments but also the 21,000 jobs that stand to be created by these hospitals. This legislation should not threaten this boost in economic growth for our communities and our states at a time our country desperately needs them the most.

Second, this provision restricts the 222 physician-owned hospitals currently operating in 32 states from growing and responding to the needs of the patients and communities they serve. Section 1156 sets forth qualifications that a physician-owned hospital must meet to just be able to apply for permission to grow from the Secretary of Health and Human Services. Besides the policy implications of a hospital needing to petition the federal government for permission to add a hospital bed if their community needs it, the qualifications listed are so restrictive that only 3 of the current 222 facilities meet them.

We are disheartened that these provisions seek to legislate away hospitals in our districts that provide much needed quality and efficient healthcare for our constituents. As this bill continues through the legislative process at such a rapid speed, it is our hope these

restrictions are changed so that our constituents can continue to have access to the great care they are currently receiving.

SAM JOHNSON
WALLY HERGER
PAUL RYAN
DAVE CAMP
KEVIN BRADY
JOHN LINDER
DEAN HELLER

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