

117TH CONGRESS  
1ST SESSION

# H. R. 1976

To establish an improved Medicare for All national health insurance program.

---

## IN THE HOUSE OF REPRESENTATIVES

MARCH 17, 2021

Ms. JAYAPAL (for herself, Ms. ADAMS, Ms. BARRAGÁN, Ms. BASS, Mr. BEYER, Mr. BLUMENAUER, Ms. BONAMICI, Mr. BOWMAN, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. BROWN, Ms. BUSH, Mr. CARBAJAL, Mr. CÁRDENAS, Mr. CARSON, Mr. CARTWRIGHT, Ms. CHU, Mr. CICILLINE, Ms. CLARK of Massachusetts, Ms. CLARKE of New York, Mr. CLEAVER, Mr. COHEN, Mr. DEUTCH, Mr. DANNY K. DAVIS of Illinois, Mr. DEFazio, Ms. DEGETTE, Mr. DESAULNIER, Mrs. DINGELL, Mr. DOGGETT, Mr. MICHAEL F. DOYLE of Pennsylvania, Ms. ESCOBAR, Mr. ESPAILLAT, Ms. LOIS FRANKEL of Florida, Mr. GALLEGO, Mr. GARCÍA of Illinois, Mr. GOMEZ, Mr. GREEN of Texas, Mr. GRIJALVA, Mr. HARDER of California, Mr. HASTINGS, Mrs. HAYES, Mr. HIGGINS of New York, Mr. HUFFMAN, Ms. JACKSON LEE, Ms. JACOBS of California, Mr. JEFFRIES, Mr. JOHNSON of Georgia, Mr. JONES, Mr. KAHELE, Mr. KEATING, Ms. KELLY of Illinois, Mr. KHANNA, Mr. KILDEE, Mrs. KIRKPATRICK, Mr. LANGEVIN, Mrs. LAWRENCE, Ms. LEE of California, Ms. LEGER FERNANDEZ, Mr. LEVIN of Michigan, Mr. LEVIN of California, Mr. LIEU, Mr. LOWENTHAL, Mrs. CAROLYN B. MALONEY of New York, Mr. MCGOVERN, Mr. MCNERNEY, Mr. MEEKS, Ms. MENG, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Ms. NEWMAN, Ms. NORTON, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PANETTA, Mr. PAYNE, Mr. PERLMUTTER, Ms. PINGREE, Mr. POCAN, Ms. PORTER, Ms. PRESSLEY, Mr. RASKIN, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. SABLAN, Ms. SÁNCHEZ, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SHERMAN, Mr. SMITH of Washington, Ms. SPEIER, Mr. SWALWELL, Mr. TAKANO, Mr. THOMPSON of Mississippi, Mr. THOMPSON of California, Ms. TITUS, Ms. TLAIB, Mr. TONKO, Mr. TORRES of New York, Mrs. TRAHAN, Mr. VARGAS, Mr. VEASEY, Ms. VELÁZQUEZ, Ms. WATERS, Mrs. WATSON COLEMAN, Mr. WELCH, Ms. WILD, Ms. WILLIAMS of Georgia, Ms. WILSON of Florida, Mr. YARMUTH, Mr. PALLONE, and Mr. PRICE of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Rules, Oversight and Reform, Armed Services, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration

of such provisions as fall within the jurisdiction of the committee concerned

---

# A BILL

To establish an improved Medicare for All national health insurance program.

1        *Be it enacted by the Senate and House of Representa-*  
 2        *tives of the United States of America in Congress assembled,*

3        **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4        (a) **SHORT TITLE.**—This Act may be cited as the  
 5        “Medicare for All Act of 2021”.

6        (b) **TABLE OF CONTENTS.**—The table of contents of  
 7        this Act is as follows:

Sec. 1. Short title; table of contents.

**TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL  
PROGRAM; UNIVERSAL COVERAGE; ENROLLMENT**

Sec. 101. Establishment of the Medicare for All Program.

Sec. 102. Universal coverage.

Sec. 103. Freedom of choice.

Sec. 104. Non-discrimination.

Sec. 105. Enrollment.

Sec. 106. Effective date of benefits.

Sec. 107. Prohibition against duplicating coverage.

**TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE  
BENEFITS AND BENEFITS FOR LONG-TERM CARE**

Sec. 201. Comprehensive benefits.

Sec. 202. No cost-sharing; other limitations.

Sec. 203. Exclusions and limitations.

Sec. 204. Coverage of long-term care services.

**TITLE III—PROVIDER PARTICIPATION**

Sec. 301. Provider participation and standards; whistleblower protections.

Sec. 302. Qualifications for providers.

Sec. 303. Use of private contracts.

**TITLE IV—ADMINISTRATION**

Subtitle A—General Administration Provisions

- Sec. 401. Administration.
- Sec. 402. Consultation.
- Sec. 403. Regional administration.
- Sec. 404. Beneficiary ombudsman.
- Sec. 405. Conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

- Sec. 411. Application of Federal sanctions to all fraud and abuse under the Medicare for All Program.

TITLE V—QUALITY ASSESSMENT

- Sec. 501. Quality standards.
- Sec. 502. Addressing health care disparities.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

- Sec. 601. National health budget.

Subtitle B—Payments to Providers

- Sec. 611. Payments to institutional providers based on global budgets.
- Sec. 612. Payment to individual providers through fee-for-service.
- Sec. 613. Ensuring accurate valuation of services under the Medicare physician fee schedule.
- Sec. 614. Payment prohibitions; capital expenditures; special projects.
- Sec. 615. Office of Health Equity.
- Sec. 616. Office of Primary Care.
- Sec. 617. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

- Sec. 701. Universal Medicare Trust Fund.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

- Sec. 801. Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers' compensation.
- Sec. 802. Application of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
- Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

- Sec. 901. Relationship to existing Federal health programs.
- Sec. 902. Sunset of provisions related to the State Exchanges.
- Sec. 903. Sunset of provisions related to pay for performance programs.

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

- Sec. 1001. Medicare for all transition over two years.  
 Sec. 1002. Establishment of the Medicare transition buy-in.

Subtitle B—Transitional Medicare Reforms

- Sec. 1011. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.  
 Sec. 1012. Ensuring continuity of care.

TITLE XI—MISCELLANEOUS

- Sec. 1101. Definitions.  
 Sec. 1102. Rules of construction.  
 Sec. 1103. No use of resources for law enforcement of certain registration requirements.

1 **TITLE I—ESTABLISHMENT OF**  
 2 **THE MEDICARE FOR ALL PRO-**  
 3 **GRAM; UNIVERSAL COV-**  
 4 **ERAGE; ENROLLMENT**

5 **SEC. 101. ESTABLISHMENT OF THE MEDICARE FOR ALL**  
 6 **PROGRAM.**

7 There is hereby established a national health insur-  
 8 ance program to provide comprehensive protection against  
 9 the costs of health care and health-related services, in ac-  
 10 cordance with the standards specified in, or established  
 11 under, this Act.

12 **SEC. 102. UNIVERSAL COVERAGE.**

13 (a) IN GENERAL.—Every individual who is a resident  
 14 of the United States is entitled to benefits for health care  
 15 services under this Act. The Secretary shall promulgate  
 16 a rule that provides criteria for determining residency for  
 17 eligibility purposes under this Act.

1 (b) TREATMENT OF OTHER INDIVIDUALS.—The Sec-  
2 retary may make eligible for benefits for health care serv-  
3 ices under this Act other individuals not described in sub-  
4 section (a), and regulate the eligibility of such individuals,  
5 to ensure that every person in the United States has ac-  
6 cess to health care. In regulating such eligibility, the Sec-  
7 retary shall ensure that individuals are not allowed to  
8 travel to the United States for the sole purpose of obtain-  
9 ing health care items and services provided under the pro-  
10 gram established under this Act.

11 **SEC. 103. FREEDOM OF CHOICE.**

12 Any individual entitled to benefits under this Act may  
13 obtain health services from any institution, agency, or in-  
14 dividual qualified to participate under this Act.

15 **SEC. 104. NON-DISCRIMINATION.**

16 (a) IN GENERAL.—No person shall, on the basis of  
17 race, color, national origin, age, disability, marital status,  
18 citizenship status, primary language use, genetic condi-  
19 tions, previous or existing medical conditions, religion, or  
20 sex, including sex stereotyping, gender identity, sexual ori-  
21 entation, and pregnancy and related medical conditions  
22 (including termination of pregnancy), be excluded from  
23 participation in or be denied the benefits of the program  
24 established under this Act (except as expressly authorized  
25 by this Act for purposes of enforcing eligibility standards

1 described in section 102), or be subject to any reduction  
2 of benefits or other discrimination by any participating  
3 provider (as defined in section 301), or any entity con-  
4 ducting, administering, or funding a health program or  
5 activity, including contracts of insurance, pursuant to this  
6 Act.

7 (b) CLAIMS OF DISCRIMINATION.—

8 (1) IN GENERAL.—The Secretary shall establish  
9 a procedure for adjudication of administrative com-  
10 plaints alleging a violation of subsection (a).

11 (2) JURISDICTION.—Any person aggrieved by a  
12 violation of subsection (a) by a covered entity may  
13 file suit in any district court of the United States  
14 having jurisdiction of the parties. A person may  
15 bring an action under this paragraph concurrently  
16 as such administrative remedies as established in  
17 paragraph (1).

18 (3) DAMAGES.—If the court finds a violation of  
19 subsection (a), the court may grant compensatory  
20 and punitive damages, declaratory relief, injunctive  
21 relief, attorneys' fees and costs, or other relief as ap-  
22 propriate.

23 (c) CONTINUED APPLICATION OF LAWS.—Nothing in  
24 this title (or an amendment made by this title) shall be  
25 construed to invalidate or otherwise limit any of the rights,

1 remedies, procedures, or legal standards available to indi-  
2 viduals aggrieved under section 1557 of the Patient Pro-  
3 tection and Affordable Care Act (42 U.S.C. 18116), title  
4 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et  
5 seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.  
6 2000e et seq.), title IX of the Education Amendments of  
7 1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-  
8 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-  
9 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing  
10 in this title (or an amendment to this title) shall be con-  
11 strued to supersede State laws that provide additional pro-  
12 tections against discrimination on any basis described in  
13 subsection (a).

14 **SEC. 105. ENROLLMENT.**

15 (a) IN GENERAL.—The Secretary shall provide a  
16 mechanism for the enrollment of individuals eligible for  
17 benefits under this Act. The mechanism shall—

18 (1) include a process for the automatic enroll-  
19 ment of individuals at the time of birth in the  
20 United States (or upon establishment of residency in  
21 the United States);

22 (2) provide for the enrollment, as of the dates  
23 described in section 106, of all individuals who are  
24 eligible to be enrolled as of such dates, as applicable;  
25 and

1           (3) include a process for the enrollment of indi-  
2           viduals made eligible for health care services under  
3           section 102(b).

4           (b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—  
5           In conjunction with an individual’s enrollment for benefits  
6           under this Act, the Secretary shall provide for the issuance  
7           of a Universal Medicare card that shall be used for pur-  
8           poses of identification and processing of claims for bene-  
9           fits under this program. The card shall not include an in-  
10          dividual’s Social Security number.

11       **SEC. 106. EFFECTIVE DATE OF BENEFITS.**

12          (a) IN GENERAL.—Except as provided in subsection  
13       (b), benefits shall first be available under this Act for  
14       items and services furnished 2 years after the date of the  
15       enactment of this Act.

16          (b) COVERAGE FOR CERTAIN INDIVIDUALS.—

17               (1) IN GENERAL.—For any eligible individual  
18       who—

19                       (A) has not yet attained the age of 19 as  
20                       of the date that is 1 year after the date of the  
21                       enactment of this Act; or

22                       (B) has attained the age of 55 as of the  
23                       date that is 1 year after the date of the enact-  
24                       ment of this Act,



1 benefits shall first be available under this Act for  
2 items and services furnished as of such date.

3 (2) OPTION TO CONTINUE IN OTHER COVERAGE  
4 DURING TRANSITION PERIOD.—Any person who is  
5 eligible to receive benefits as described in paragraph  
6 (1) may opt to maintain any coverage described in  
7 section 901, private health insurance coverage, or  
8 coverage offered pursuant to subtitle A of title X  
9 (including the amendments made by such subtitle)  
10 until the date described in subsection (a).

11 **SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.**

12 (a) IN GENERAL.—Beginning on the effective date  
13 described in section 106(a), it shall be unlawful for—

14 (1) a private health insurer to sell health insur-  
15 ance coverage that duplicates the benefits provided  
16 under this Act; or

17 (2) an employer to provide benefits for an em-  
18 ployee, former employee, or the dependents of an  
19 employee or former employee that duplicate the ben-  
20 efits provided under this Act.

21 (b) CONSTRUCTION.—Nothing in this Act shall be  
22 construed as prohibiting the sale of health insurance cov-  
23 erage for any additional benefits not covered by this Act,  
24 including additional benefits that an employer may provide

1 to employees or their dependents, or to former employees  
2 or their dependents.

3 **TITLE II—COMPREHENSIVE BEN-**  
4 **EFITS, INCLUDING PREVEN-**  
5 **TIVE BENEFITS AND BENE-**  
6 **FITS FOR LONG-TERM CARE**

7 **SEC. 201. COMPREHENSIVE BENEFITS.**

8 (a) IN GENERAL.—Subject to the other provisions of  
9 this title and titles IV through IX, individuals enrolled for  
10 benefits under this Act are entitled to have payment made  
11 by the Secretary to an eligible provider for the following  
12 items and services if medically necessary or appropriate  
13 for the maintenance of health or for the diagnosis, treat-  
14 ment, or rehabilitation of a health condition:

15 (1) Hospital services, including inpatient and  
16 outpatient hospital care, including 24-hour-a-day  
17 emergency services and inpatient prescription drugs.

18 (2) Ambulatory patient services.

19 (3) Primary and preventive services, including  
20 chronic disease management.

21 (4) Prescription drugs and medical devices, in-  
22 cluding outpatient prescription drugs, medical de-  
23 vices, and biological products.

24 (5) Mental health and substance use treatment  
25 services, including inpatient care.

1 (6) Laboratory and diagnostic services.

2 (7) Comprehensive reproductive, maternity, and  
3 newborn care.

4 (8) Oral health, audiology, and vision services.

5 (9) Rehabilitative and habilitative services and  
6 devices.

7 (10) Emergency services and transportation.

8 (11) Early and periodic screening, diagnostic,  
9 and treatment services, as described in sections  
10 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and  
11 1905(r) of the Social Security Act (42 U.S.C.  
12 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B);  
13 1396d(r)).

14 (12) Necessary transportation to receive health  
15 care services for persons with disabilities, older indi-  
16 viduals with functional limitations, or low-income in-  
17 dividuals (as determined by the Secretary).

18 (13) Long-term care services and support (as  
19 described in section 204).

20 (14) Hospice care.

21 (15) Services provided by a licensed marriage  
22 and family therapist or a licensed mental health  
23 counselor.

24 (b) REVISION.—The Secretary shall, at least annu-  
25 ally, and on a regular basis, evaluate whether the benefits

1 package should be improved to promote the health of bene-  
2 ficiaries, account for changes in medical practice or new  
3 information from medical research, or respond to other  
4 relevant developments in health science, and shall make  
5 recommendations to Congress regarding any such im-  
6 provements. Such recommendations may not include a rec-  
7 ommendation to eliminate any benefit.

8 (c) HEARINGS.—

9 (1) IN GENERAL.—The Committee on Energy  
10 and Commerce and the Committee on Ways and  
11 Means of the House of Representatives shall, not  
12 less frequently than annually, hold a hearing on the  
13 recommendations submitted by the Secretary under  
14 subsection (b).

15 (2) EXERCISE OF RULEMAKING AUTHORITY.—

16 Paragraph (1) is enacted—

17 (A) as an exercise of rulemaking power of  
18 the House of Representatives, and, as such,  
19 shall be considered as part of the rules of the  
20 House, and such rules shall supersede any other  
21 rule of the House only to the extent that rule  
22 is inconsistent therewith; and

23 (B) with full recognition of the constitu-  
24 tional right of either House to change such  
25 rules (so far as relating to the procedure in

1 such House) at any time, in the same manner,  
2 and to the same extent as in the case of any  
3 other rule of the House.

4 (d) COMPLEMENTARY AND INTEGRATIVE MEDI-  
5 CINE.—

6 (1) IN GENERAL.—In carrying out subsection  
7 (b), the Secretary shall consult with the persons de-  
8 scribed in paragraph (2) with respect to—

9 (A) identifying specific complementary and  
10 integrative medicine practices that are appro-  
11 priate to include in the benefits package; and

12 (B) identifying barriers to the effective  
13 provision and integration of such practices into  
14 the delivery of health care, and identifying  
15 mechanisms for overcoming such barriers.

16 (2) CONSULTATION.—In accordance with para-  
17 graph (1), the Secretary shall consult with—

18 (A) the Director of the National Center for  
19 Complementary and Integrative Health;

20 (B) the Commissioner of Food and Drugs;

21 (C) institutions of higher education, pri-  
22 vate research institutes, and individual re-  
23 searchers with extensive experience in com-  
24plementary and alternative medicine and the in-

1           tegration of such practices into the delivery of  
2           health care;

3                   (D) nationally recognized providers of com-  
4           plementary and integrative medicine; and

5                   (E) such other officials, entities, and indi-  
6           viduals with expertise on complementary and  
7           integrative medicine as the Secretary deter-  
8           mines appropriate.

9           (e) STATES MAY PROVIDE ADDITIONAL BENE-  
10       FITS.—Individual States may provide additional benefits  
11       for the residents of such States, as determined by such  
12       State, and may provide benefits to individuals not eligible  
13       for benefits under this Act, at the expense of the State,  
14       subject to the requirements specified in section 1102.

15       **SEC. 202. NO COST-SHARING; OTHER LIMITATIONS.**

16           (a) IN GENERAL.—The Secretary shall ensure that  
17       no cost-sharing, including deductibles, coinsurance, copay-  
18       ments, or similar charges, is imposed on an individual for  
19       any benefits provided under this Act.

20           (b) NO BALANCE BILLING.—No provider may impose  
21       a charge to an enrolled individual for covered services for  
22       which benefits are provided under this Act.

23           (c) NO PRIOR AUTHORIZATION.—Benefits provided  
24       under this Act shall be covered without any need for any

1 prior authorization determination and without any limita-  
2 tion applied through the use of step therapy protocols.

3 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

4 (a) IN GENERAL.—Benefits for items and services  
5 are not available under this Act unless the items and serv-  
6 ices meet the standards developed by the Secretary pursu-  
7 ant to section 201(a).

8 (b) TREATMENT OF EXPERIMENTAL ITEMS AND  
9 SERVICES AND DRUGS.—

10 (1) IN GENERAL.—In applying subsection (a),  
11 the Secretary shall make national coverage deter-  
12 minations with respect to items and services that are  
13 experimental in nature. Such determinations shall be  
14 consistent with the national coverage determination  
15 process as defined in section 1869(f)(1)(B) of the  
16 Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

17 (2) APPEALS PROCESS.—The Secretary shall  
18 establish a process by which individuals can appeal  
19 coverage decisions. The process shall, as much as is  
20 feasible, follow the process for appeals under the  
21 Medicare program described in section 1869 of the  
22 Social Security Act (42 U.S.C. 1395ff).

23 (c) APPLICATION OF PRACTICE GUIDELINES.—

24 (1) IN GENERAL.—In the case of items and  
25 services for which the Department of Health and

1 Human Services has recognized a national practice  
2 guideline, such items and services shall be deemed to  
3 meet the standards specified in section 201(a) if  
4 they have been provided in accordance with such  
5 guideline. For purposes of this subsection, an item  
6 or service not provided in accordance with a practice  
7 guideline shall be deemed to have been provided in  
8 accordance with the guideline if the health care pro-  
9 vider providing the item or service—

10 (A) exercised appropriate professional  
11 judgment in accordance with the laws and re-  
12 quirements of the State in which such item or  
13 service is furnished in deviating from the guide-  
14 line;

15 (B) acted in the best interest of the indi-  
16 vidual receiving the item or service; and

17 (C) acted in a manner consistent with the  
18 individual's wishes.

19 (2) OVERRIDE OF STANDARDS.—

20 (A) IN GENERAL.—An individual's treating  
21 physician or other health care professional au-  
22 thorized to exercise independent professional  
23 judgment in implementing a patient's medical  
24 or nursing care plan in accordance with the  
25 scope of practice, licensure, and other law of



1 the State where items and services are to be  
2 furnished may override practice standards es-  
3 tablished pursuant to section 201(a) or practice  
4 guidelines described in paragraph (1), including  
5 such standards and guidelines that are imple-  
6 mented by a provider through the use of health  
7 information technology, such as electronic  
8 health record technology, clinical decision sup-  
9 port technology, and computerized order entry  
10 programs.

11 (B) LIMITATION.—An override described  
12 in subparagraph (A) shall, in the professional  
13 judgment of such physician, nurse, or health  
14 care professional, be—

15 (i) consistent with such physician’s,  
16 nurse’s, or health care professional’s deter-  
17 mination of medical necessity and appro-  
18 priateness or nursing assessment;

19 (ii) in the best interests of the indi-  
20 vidual; and

21 (iii) consistent with the individual’s  
22 wishes.

23 **SEC. 204. COVERAGE OF LONG-TERM CARE SERVICES.**

24 (a) IN GENERAL.—Subject to the other provisions of  
25 this Act, individuals enrolled for benefits under this Act

1 are entitled to the following long-term services and sup-  
2 ports and to have payment made by the Secretary to an  
3 eligible provider for such services and supports if medically  
4 necessary and appropriate and in accordance with the  
5 standards established in this Act, for maintenance of  
6 health or for care, services, diagnosis, treatment, or reha-  
7 bilitation that is related to a medically determinable condi-  
8 tion, whether physical or mental, of health, injury, or age  
9 that—

10           (1) causes a functional limitation in performing  
11           one or more activities of daily living; or

12           (2) requires a similar need of assistance in per-  
13           forming instrumental activities of daily living.

14           (b) ELIGIBILITY.—An individual shall be eligible for  
15 services and supports described in this section if such indi-  
16 vidual has one or more medically determinable conditions  
17 described in subsection (a).

18           (c) SERVICES AND SUPPORTS.—Long-term services  
19 and supports under this section shall be tailored to an in-  
20 dividual’s needs, as determined through assessment, and  
21 shall be defined by the Secretary to—

22           (1) include any long-term nursing services for  
23           the enrollee, whether provided in an institution or in  
24           a home and community-based setting;

1           (2) provide coverage for a broad spectrum of  
2 long-term services and supports, including for home  
3 and community-based services and other care pro-  
4 vided through non-institutional settings;

5           (3) provide coverage that meets the physical,  
6 mental, and social needs of recipients while allowing  
7 recipients their maximum possible autonomy and  
8 their maximum possible civic, social, and economic  
9 participation;

10          (4) prioritize delivery of long-term services and  
11 supports through home and community-based serv-  
12 ices over institutionalization;

13          (5) unless an individual elects otherwise, ensure  
14 that recipients will receive home and community  
15 based long-term services and supports (as defined in  
16 subsection (f)(4)), regardless of the individuals's  
17 type or level of disability, service need, or age;

18          (6) be provided with the goal of enabling per-  
19 sons with disabilities to receive services in the least  
20 restrictive and most integrated setting appropriate  
21 to the individual's needs;

22          (7) be provided in such a manner that allows  
23 persons with disabilities to maintain their independ-  
24 ence, self-determination, and dignity;

1           (8) provide long-term services and supports  
2           that are of equal quality and equally accessible  
3           across geographic regions; and

4           (9) ensure that long-term services and supports  
5           provide recipient's the option of self-direction of  
6           services from either the recipient or care coordina-  
7           tors of the recipient's choosing.

8           (d) PUBLIC CONSULTATION.—In developing regula-  
9           tions to implement this section, the Secretary shall consult  
10          with an advisory commission on long-term services and  
11          supports that includes—

12           (1) people with disabilities who use long-term  
13           services and supports and older adults who use long-  
14           term services and supports;

15           (2) representatives of people with disabilities  
16           and representatives of older adults;

17           (3) groups that represent the diversity of the  
18           population of people living with disabilities, including  
19           racial, ethnic, national origin, primary language use,  
20           age, sex, including gender identity and sexual ori-  
21           entation, geographical, and socioeconomic diversity;

22           (4) providers of long-term services and sup-  
23           ports, including family attendants and family care-  
24           givers, and members of organized labor;

25           (5) disability rights organizations; and

1           (6) relevant academic institutions and research-  
2           ers.

3           (e) BUDGETING AND PAYMENTS.—Budgeting and  
4 payments for long-term services and supports provided  
5 under this section shall be made in accordance with the  
6 provisions under title VI.

7           (f) DEFINITIONS.—In this section:

8           (1) The term “long-term services and supports”  
9           means long-term care, treatment, maintenance, or  
10          services needed to support the activities of daily liv-  
11          ing and instrumental activities of daily living, includ-  
12          ing home and community-based services and any ad-  
13          ditional services and supports identified by the Sec-  
14          retary to support people with disabilities to live,  
15          work, and participate in their communities.

16          (2) The term “activities of daily living” means  
17          basic personal everyday activities, including tasks  
18          such as eating, toileting, grooming, dressing, bath-  
19          ing, and transferring.

20          (3) The term “instrumental activities of daily  
21          living” means activities related to living independ-  
22          ently in the community, including but not limited to,  
23          meal planning and preparation, managing finances,  
24          shopping for food, clothing, and other essential  
25          items, performing essential household chores, com-

1 communicating by phone or other media, and traveling  
2 around and participating in the community.

3 (4) The term “home and community-based  
4 services” means the home and community-based  
5 services that are coverable under subsections (c),  
6 (d), (i), and (k) of section 1915 of the Social Secu-  
7 rity Act (42 U.S.C. 1396n), and as defined by the  
8 Secretary, including as defined in the home and  
9 community-based services settings rule in sections  
10 441.530 and 441.710 of title 42, Code of Federal  
11 Regulations (or a successor regulation).

## 12 **TITLE III—PROVIDER** 13 **PARTICIPATION**

### 14 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS;** 15 **WHISTLEBLOWER PROTECTIONS.**

16 (a) IN GENERAL.—An individual or other entity fur-  
17 nishing any covered item or service under this Act is not  
18 a qualified provider unless the individual or entity—

19 (1) is a qualified provider of the items or serv-  
20 ices under section 302;

21 (2) has filed with the Secretary a participation  
22 agreement described in subsection (b); and

23 (3) meets, as applicable, such other qualifica-  
24 tions and conditions with respect to a provider of  
25 services under title XVIII of the Social Security Act

1 as described in section 1866 of the Social Security  
2 Act (42 U.S.C. 1395cc).

3 (b) REQUIREMENTS IN PARTICIPATION AGREE-  
4 MENT.—

5 (1) IN GENERAL.—A participation agreement  
6 described in this subsection between the Secretary  
7 and a provider shall provide at least for the fol-  
8 lowing:

9 (A) Items and services to eligible persons  
10 shall be furnished by the provider without dis-  
11 crimination, in accordance with section 104(a).  
12 Nothing in this subparagraph shall be con-  
13 strued as requiring the provision of a type or  
14 class of items or services that are outside the  
15 scope of the provider's normal practice.

16 (B) No charge will be made to any enrolled  
17 individual for any covered items or services  
18 other than for payment authorized by this Act.

19 (C) The provider agrees to furnish such in-  
20 formation as may be reasonably required by the  
21 Secretary, in accordance with uniform reporting  
22 standards established under section 401(b)(1),  
23 for—

24 (i) quality review by designated enti-  
25 ties;

1           (ii) making payments under this Act,  
2           including the examination of records as  
3           may be necessary for the verification of in-  
4           formation on which such payments are  
5           based;

6           (iii) statistical or other studies re-  
7           quired for the implementation of this Act;  
8           and

9           (iv) such other purposes as the Sec-  
10          retary may specify.

11          (D) In the case of a provider that is not  
12          an individual, the provider agrees not to employ  
13          or use for the provision of health services any  
14          individual or other provider that has had a par-  
15          ticipation agreement under this subsection ter-  
16          minated for cause. The Secretary may authorize  
17          such employment or use on a case-by-case  
18          basis.

19          (E) In the case of a provider paid under  
20          a fee-for-service basis for items and services  
21          furnished under this Act, the provider agrees to  
22          submit bills and any required supporting docu-  
23          mentation relating to the provision of covered  
24          items and services within 30 days after the date  
25          of providing such items and services.



1           (F) In the case of an institutional provider  
2           paid pursuant to section 611, the provider  
3           agrees to submit information and any other re-  
4           quired supporting documentation as may be  
5           reasonably required by the Secretary within 30  
6           days after the date of providing such items and  
7           services and in accordance with the uniform re-  
8           porting standards established under section  
9           401(b)(1), including information on a quarterly  
10          basis that—

11                   (i) relates to the provision of covered  
12                   items and services; and

13                   (ii) describes items and services fur-  
14                   nished with respect to specific individuals.

15          (G) In the case of a provider that receives  
16          payment for items and services furnished under  
17          this Act based on diagnosis-related coding, pro-  
18          cedure coding, or other coding system or data,  
19          the provider agrees—

20                   (i) to disclose to the Secretary any  
21                   system or index of coding or classifying pa-  
22                   tient symptoms, diagnoses, clinical inter-  
23                   ventions, episodes, or procedures that such  
24                   provider utilizes for global budget negotia-  
25                   tions under title VI or for meeting any

1 other payment, documentation, or data col-  
2 lection requirements under this Act; and

3 (ii) not to use any such system or  
4 index to establish financial incentives or  
5 disincentives for health care professionals,  
6 or that is proprietary, interferes with the  
7 medical or nursing process, or is designed  
8 to increase the amount or number of pay-  
9 ments.

10 (H) The provider complies with the duty of  
11 provider ethics and reporting requirements de-  
12 scribed in paragraph (2).

13 (I) In the case of a provider that is not an  
14 individual, the provider agrees that no board  
15 member, executive, or administrator of such  
16 provider receives compensation from, owns  
17 stock or has other financial investments in, or  
18 serves as a board member of any entity that  
19 contracts with or provides items or services, in-  
20 cluding pharmaceutical products and medical  
21 devices or equipment, to such provider.

22 (2) PROVIDER DUTY OF ETHICS.—Each health  
23 care provider, including institutional providers, has a  
24 duty to advocate for and to act in the exclusive in-  
25 terest of each individual under the care of such pro-

1       vider according to the applicable legal standard of  
2       care, such that no financial interest or relationship  
3       impairs any health care provider’s ability to furnish  
4       necessary and appropriate care to such individual.  
5       To implement the duty established in this para-  
6       graph, the Secretary shall—

7               (A) promulgate reasonable reporting rules  
8               to evaluate participating provider compliance  
9               with this paragraph;

10              (B) prohibit participating providers,  
11              spouses, and immediate family members of par-  
12              ticipating providers, from accepting or entering  
13              into any arrangement for any bonus, incentive  
14              payment, profit-sharing, or compensation based  
15              on patient utilization or based on financial out-  
16              comes of any other provider or entity; and

17              (C) prohibit participating providers or any  
18              board member or representative of such pro-  
19              vider from serving as board members for or re-  
20              ceiving any compensation, stock, or other finan-  
21              cial investment in an entity that contracts with  
22              or provides items or services (including pharma-  
23              ceutical products and medical devices or equip-  
24              ment) to such provider.

1           (3) TERMINATION OF PARTICIPATION AGREE-  
2           MENT.—

3           (A) IN GENERAL.—Participation agree-  
4           ments may be terminated, with appropriate no-  
5           tice—

6                     (i) by the Secretary for failure to meet  
7                     the requirements of this Act;

8                     (ii) in accordance with the provisions  
9                     described in section 411; or

10                    (iii) by a provider.

11           (B) TERMINATION PROCESS.—Providers  
12           shall be provided notice and a reasonable oppor-  
13           tunity to correct deficiencies before the Sec-  
14           retary terminates an agreement unless a more  
15           immediate termination is required for public  
16           safety or similar reasons.

17           (C) PROVIDER PROTECTIONS.—

18                     (i) PROHIBITION.—The Secretary may  
19                     not terminate a participation agreement or  
20                     in any other way discriminate against, or  
21                     cause to be discriminated against, any cov-  
22                     ered provider or authorized representative  
23                     of the provider, on account of such pro-  
24                     vider or representative—

1 (I) providing, causing to be pro-  
2 vided, or being about to provide or  
3 cause to be provided to the provider,  
4 the Federal Government, or the attor-  
5 ney general of a State information re-  
6 lating to any violation of, or any act  
7 or omission the provider or represent-  
8 ative reasonably believes to be a viola-  
9 tion of, any provision of this title (or  
10 an amendment made by this title);

11 (II) testifying or being about to  
12 testify in a proceeding concerning  
13 such violation;

14 (III) assisting or participating, or  
15 being about to assist or participate, in  
16 such a proceeding; or

17 (IV) objecting to, or refusing to  
18 participate in, any activity, policy,  
19 practice, or assigned task that the  
20 provider or representative reasonably  
21 believes to be in violation of any provi-  
22 sion of this Act (including any amend-  
23 ment made by this Act), or any order,  
24 rule, regulation, standard, or ban

1 under this Act (including any amend-  
2 ment made by this Act).

3 (ii) COMPLAINT PROCEDURE.—A pro-  
4 vider or representative who believes that he  
5 or she has been discriminated against in  
6 violation of this section may seek relief in  
7 accordance with the procedures, notifica-  
8 tions, burdens of proof, remedies, and stat-  
9 utes of limitation set forth in section  
10 2087(b) of title 15, United States Code.

11 (c) WHISTLEBLOWER PROTECTIONS.—

12 (1) RETALIATION PROHIBITED.—No person  
13 may discharge or otherwise discriminate against any  
14 employee because the employee or any person acting  
15 pursuant to a request of the employee—

16 (A) notified the Secretary or the employ-  
17 ee's employer of any alleged violation of this  
18 title, including communications related to car-  
19 rying out the employee's job duties;

20 (B) refused to engage in any practice made  
21 unlawful by this title, if the employee has iden-  
22 tified the alleged illegality to the employer;

23 (C) testified before or otherwise provided  
24 information relevant for Congress or for any

1 Federal or State proceeding regarding any pro-  
2 vision (or proposed provision) of this title;

3 (D) commenced, caused to be commenced,  
4 or is about to commence or cause to be com-  
5 menced a proceeding under this title;

6 (E) testified or is about to testify in any  
7 such proceeding; or

8 (F) assisted or participated or is about to  
9 assist or participate in any manner in such a  
10 proceeding or in any other manner in such a  
11 proceeding or in any other action to carry out  
12 the purposes of this title.

13 (2) ENFORCEMENT ACTION.—Any employee  
14 covered by this section who alleges discrimination by  
15 an employer in violation of paragraph (1) may bring  
16 an action, subject to the statute of limitations in the  
17 anti-retaliation provisions of the False Claims Act  
18 and the rules and procedures, legal burdens of proof,  
19 and remedies applicable under the employee protec-  
20 tions provisions of the Surface Transportation As-  
21 sistance Act.

22 (3) APPLICATION.—

23 (A) Nothing in this subsection shall be  
24 construed to diminish the rights, privileges, or  
25 remedies of any employee under any Federal or

1 State law or regulation, including the rights  
2 and remedies against retaliatory action under  
3 the False Claims Act (31 U.S.C. 3730(h)), or  
4 under any collective bargaining agreement. The  
5 rights and remedies in this section may not be  
6 waived by any agreement, policy, form, or con-  
7 dition of employment.

8 (B) Nothing in this subsection shall be  
9 construed to preempt or diminish any other  
10 Federal or State law or regulation against dis-  
11 crimination, demotion, discharge, suspension,  
12 threats, harassment, reprimand, retaliation, or  
13 any other manner of discrimination, including  
14 the rights and remedies against retaliatory ac-  
15 tion under the False Claims Act (31 U.S.C.  
16 3730(h)).

17 (4) DEFINITIONS.—In this subsection:

18 (A) EMPLOYER.—The term “employer”  
19 means any person engaged in profit or non-  
20 profit business or industry, including one or  
21 more individuals, partnerships, associations,  
22 corporations, trusts, professional membership  
23 organization including a certification, discipli-  
24 nary, or other professional body, unincorporated  
25 organizations, nongovernmental organizations,



1 or trustees, and subject to liability for violating  
2 the provisions of this Act.

3 (B) EMPLOYEE.—The term “employee”  
4 means any individual performing activities  
5 under this Act on behalf of an employer.

6 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

7 (a) IN GENERAL.—A health care provider is consid-  
8 ered to be qualified to furnish covered items and services  
9 under this Act if the provider is licensed or certified to  
10 furnish such items and services in the State in which the  
11 individual receiving such items or services is located and  
12 meets—

13 (1) the requirements of such State’s law to fur-  
14 nish such items and services; and

15 (2) applicable requirements of Federal law to  
16 furnish such items and services.

17 (b) LIMITATION.—An entity or provider shall not be  
18 qualified to furnish covered items and services under this  
19 Act if the entity or provider provides no items and services  
20 directly to individuals, including—

21 (1) entities or providers that contract with  
22 other entities or providers to provide such items and  
23 services; and

24 (2) entities that are currently approved to co-  
25 ordinate care plans under the Medicare Advantage

1 program established in part C of title XVIII of the  
2 Social Security Act (42 U.S.C. 1851 et seq.) but do  
3 not directly provide items and services of such care  
4 plans.

5 (c) MINIMUM PROVIDER STANDARDS.—

6 (1) IN GENERAL.—The Secretary shall estab-  
7 lish, evaluate, and update national minimum stand-  
8 ards to ensure the quality of items and services pro-  
9 vided under this Act and to monitor efforts by  
10 States to ensure the quality of such items and serv-  
11 ices. A State may establish additional minimum  
12 standards which providers shall meet with respect to  
13 items and services provided in such State.

14 (2) NATIONAL MINIMUM STANDARDS.—The  
15 Secretary shall establish national minimum stand-  
16 ards under paragraph (1) for institutional providers  
17 of services and individual health care practitioners.  
18 Except as the Secretary may specify in order to  
19 carry out this Act, a hospital, skilled nursing facility,  
20 or other institutional provider of services shall meet  
21 standards applicable to such a provider under the  
22 Medicare program under title XVIII of the Social  
23 Security Act (42 U.S.C. 1395 et seq.). Such stand-  
24 ards also may include, where appropriate, elements  
25 relating to—

- 1 (A) adequacy and quality of facilities;
- 2 (B) mandatory minimum safe registered  
3 nurse-to-patient staffing ratios and optimal  
4 staffing levels for physicians and other health  
5 care practitioners;
- 6 (C) training and competence of personnel  
7 (including requirements related to the number  
8 of or type of required continuing education  
9 hours);
- 10 (D) comprehensiveness of service;
- 11 (E) continuity of service;
- 12 (F) patient waiting time, access to serv-  
13 ices, and preferences; and
- 14 (G) performance standards, including orga-  
15 nization, facilities, structure of services, effi-  
16 ciency of operation, and outcome in palliation,  
17 improvement of health, stabilization, cure, or  
18 rehabilitation.

19 (3) TRANSITION IN APPLICATION.—If the Sec-  
20 retary provides for additional requirements for pro-  
21 viders under this subsection, any such additional re-  
22 quirement shall be implemented in a manner that  
23 provides for a reasonable period during which a pre-  
24 viously qualified provider is permitted to meet such  
25 an additional requirement.

1           (4) ABILITY TO PROVIDE SERVICES.—With re-  
2           spect to any entity or provider certified to provide  
3           items and services described in section 201(a)(7),  
4           the Secretary may not prohibit such entity or pro-  
5           vider from participating for reasons other than such  
6           entity’s or provider’s ability to provide such items  
7           and services.

8           (d) FEDERAL PROVIDERS.—Any provider qualified to  
9           provide health care items and services through the Depart-  
10          ment of Veterans Affairs, the Indian Health Service, or  
11          the uniformed services (with respect to the direct care  
12          component of the TRICARE Program) is a qualifying pro-  
13          vider under this section with respect to any individual who  
14          qualifies for such items and services under applicable Fed-  
15          eral law.

16 **SEC. 303. USE OF PRIVATE CONTRACTS.**

17          (a) IN GENERAL.—This section shall apply beginning  
18          2 years after the date of the enactment of this Act.

19          (b) PARTICIPATING PROVIDERS.—

20                  (1) PRIVATE CONTRACTS FOR COVERED ITEMS  
21                  AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-  
22                  stitutional or individual provider with an agreement  
23                  in effect under section 301 may not bill or enter into  
24                  any private contract with any individual eligible for

1 benefits under the Act for any item or service that  
2 is a benefit under this Act.

3 (2) PRIVATE CONTRACTS FOR NONCOVERED  
4 ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—

5 An institutional or individual provider with an agree-  
6 ment in effect under section 301 may bill or enter  
7 into a private contract with an individual eligible for  
8 benefits under the Act for any item or service that  
9 is not a benefit under this Act only if—

10 (A) the contract and provider meet the re-  
11 quirements specified in paragraphs (3) and (4),  
12 respectively;

13 (B) such item or service is not payable or  
14 available under this Act; and

15 (C) the provider receives—

16 (i) no reimbursement under this Act  
17 directly or indirectly for such item or serv-  
18 ice, and

19 (ii) receives no amount for such item  
20 or service from an organization which re-  
21 ceives reimbursement for such items or  
22 service under this Act directly or indirectly.

23 (3) CONTRACT REQUIREMENTS.—Any contract  
24 to provide items and services described in paragraph  
25 (2) shall—

1 (A) be in writing and signed by the indi-  
2 vidual (or authorized representative of the indi-  
3 vidual) receiving the item or service before the  
4 item or service is furnished pursuant to the  
5 contract;

6 (B) not be entered into at a time when the  
7 individual is facing an emergency health care  
8 situation; and

9 (C) clearly indicate to the individual receiv-  
10 ing such items and services that by signing  
11 such a contract the individual—

12 (i) agrees not to submit a claim (or to  
13 request that the provider submit a claim)  
14 under this Act for such items or services;

15 (ii) agrees to be responsible for pay-  
16 ment of such items or services and under-  
17 stands that no reimbursement will be pro-  
18 vided under this Act for such items or  
19 services;

20 (iii) acknowledges that no limits under  
21 this Act apply to amounts that may be  
22 charged for such items or services; and

23 (iv) acknowledges that the provider is  
24 providing services outside the scope of the  
25 program under this Act.

1           (4) AFFIDAVIT.—A participating provider who  
2 enters into a contract described in paragraph (2)  
3 shall have in effect during the period any item or  
4 service is to be provided pursuant to the contract an  
5 affidavit that shall—

6           (A) identify the provider who is to furnish  
7 such noncovered item or service, and be signed  
8 by such provider;

9           (B) state that the provider will not submit  
10 any claim under this Act for any noncovered  
11 item or service provided to any individual en-  
12 rolled under this Act; and

13           (C) be filed with the Secretary no later  
14 than 10 days after the first contract to which  
15 such affidavit applies is entered into.

16           (5) ENFORCEMENT.—If a provider signing an  
17 affidavit described in paragraph (4) knowingly and  
18 willfully submits a claim under this title for any item  
19 or service provided or receives any reimbursement or  
20 amount for any such item or service provided pursu-  
21 ant to a private contract described in paragraph (2)  
22 with respect to such affidavit—

23           (A) any contract described in paragraph  
24 (2) shall be null and void;

1           (B) no payment shall be made under this  
2 title for any item or service furnished by the  
3 provider during the 2-year period beginning on  
4 the date the affidavit was signed; and

5           (C) any payment received under this title  
6 for any item or service furnished during such  
7 period shall be remitted.

8           (6) PRIVATE CONTRACTS FOR INELIGIBLE INDI-  
9 VIDUALS.—An institutional or individual provider  
10 with an agreement in effect under section 301 may  
11 bill or enter into a private contract with any indi-  
12 vidual ineligible for benefits under the Act for any  
13 item or service.

14           (c) NONPARTICIPATING PROVIDERS.—

15           (1) PRIVATE CONTRACTS FOR COVERED ITEMS  
16 AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-  
17 stitutional or individual provider with no agreement  
18 in effect under section 301 may bill or enter into  
19 any private contract with any individual eligible for  
20 benefits under the Act for any item or service that  
21 is a benefit under this Act described in title II only  
22 if the contract and provider meet the requirements  
23 specified in paragraphs (2) and (3), respectively.



1           (2) ITEMS REQUIRED TO BE INCLUDED IN CON-  
2 TRACT.—Any contract to provide items and services  
3 described in paragraph (1) shall—

4           (A) be in writing and signed by the indi-  
5 vidual (or authorized representative of the indi-  
6 vidual) receiving the item or service before the  
7 item or service is furnished pursuant to the  
8 contract;

9           (B) not be entered into at a time when the  
10 individual is facing an emergency health care  
11 situation; and

12           (C) clearly indicate to the individual receiv-  
13 ing such items and services that by signing  
14 such a contract the individual—

15           (i) acknowledges that the individual  
16 has the right to have such items or services  
17 provided by other providers for whom pay-  
18 ment would be made under this Act;

19           (ii) agrees not to submit a claim (or  
20 to request that the provider submit a  
21 claim) under this Act for such items or  
22 services even if such items or services are  
23 otherwise covered by this Act;

24           (iii) agrees to be responsible for pay-  
25 ment of such items or services and under-

1 stands that no reimbursement will be pro-  
2 vided under this Act for such items or  
3 services;

4 (iv) acknowledges that no limits under  
5 this Act apply to amounts that may be  
6 charged for such items or services; and

7 (v) acknowledges that the provider is  
8 providing services outside the scope of the  
9 program under this Act.

10 (3) AFFIDAVIT.—A provider who enters into a  
11 contract described in paragraph (1) shall have in ef-  
12 fect during the period any item or service is to be  
13 provided pursuant to the contract an affidavit that  
14 shall—

15 (A) identify the provider who is to furnish  
16 such covered item or service, and be signed by  
17 such provider;

18 (B) state that the provider will not submit  
19 any claim under this Act for any covered item  
20 or service provided to any individual enrolled  
21 under this Act during the 2-year period begin-  
22 ning on the date the affidavit is signed; and

23 (C) be filed with the Secretary no later  
24 than 10 days after the first contract to which  
25 such affidavit applies is entered into.

1           (4) ENFORCEMENT.—If a provider signing an  
2           affidavit described in paragraph (3) knowingly and  
3           willfully submits a claim under this title for any item  
4           or service provided or receives any reimbursement or  
5           amount for any such item or service provided pursu-  
6           ant to a private contract described in paragraph (1)  
7           with respect to such affidavit—

8                   (A) any contract described in paragraph  
9                   (1) shall be null and void; and

10                   (B) no payment shall be made under this  
11                   title for any item or service furnished by the  
12                   provider during the 2-year period beginning on  
13                   the date the affidavit was signed.

14           (5) PRIVATE CONTRACTS FOR NONCOVERED  
15           ITEMS AND SERVICES FOR ANY INDIVIDUAL.—An in-  
16           stitutional or individual provider with no agreement  
17           in effect under section 301 may bill or enter into a  
18           private contract with any individual for a item or  
19           service that is not a benefit under this Act.

1       **TITLE IV—ADMINISTRATION**

2               **Subtitle A—General**

3                   **Administration Provisions**

4   **SEC. 401. ADMINISTRATION.**

5       (a) GENERAL DUTIES OF THE SECRETARY.—

6               (1) IN GENERAL.—The Secretary shall develop  
7       policies, procedures, guidelines, and requirements to  
8       carry out this Act, including related to—

9                   (A) eligibility for benefits;

10                  (B) enrollment;

11                  (C) benefits provided;

12                  (D) provider participation standards and  
13       qualifications, as described in title III;

14                  (E) levels of funding;

15                  (F) methods for determining amounts of  
16       payments to providers of covered items and  
17       services, consistent with subtitle B;

18                  (G) a process for appealing or petitioning  
19       for a determination of coverage or noncoverage  
20       of items and services under this Act;

21                  (H) planning for capital expenditures and  
22       service delivery;

23                  (I) planning for health professional edu-  
24       cation funding;

1           (J) encouraging States to develop regional  
2           planning mechanisms; and

3           (K) any other regulations necessary to  
4           carry out the purposes of this Act.

5           (2) REGULATIONS.—Regulations authorized by  
6           this Act shall be issued by the Secretary in accord-  
7           ance with section 553 of title 5, United States Code.

8           (3) ACCESSIBILITY.—The Secretary shall have  
9           the obligation to ensure the timely and accessible  
10          provision of items and services that all eligible indi-  
11          viduals are entitled to under this Act.

12          (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-  
13          PORT; STUDIES.—

14           (1) UNIFORM REPORTING STANDARDS.—

15           (A) IN GENERAL.—The Secretary shall es-  
16           tablish uniform State reporting requirements  
17           and national standards to ensure an adequate  
18           national database containing information per-  
19           taining to health services practitioners, ap-  
20           proved providers, the costs of facilities and  
21           practitioners providing items and services, the  
22           quality of such items and services, the outcomes  
23           of such items and services, and the equity of  
24           health among population groups. Such database  
25           shall include, to the maximum extent feasible

1 without compromising patient privacy, health  
2 outcome measures used under this Act, and to  
3 the maximum extent feasible without excessively  
4 burdening providers, a description of the stand-  
5 ards and qualifications, levels of finding, and  
6 methods described in subparagraphs (D)  
7 through (F) of subsection (a)(1).

8 (B) REQUIRED DATA DISCLOSURES.—In  
9 establishing reporting requirements and stand-  
10 ards under subparagraph (A), the Secretary  
11 shall require a provider with an agreement in  
12 effect under section 301 to disclose to the Sec-  
13 retary, in a time and manner specified by the  
14 Secretary, the following (as applicable to the  
15 type of provider):

16 (i) Any data the provider is required  
17 to report or does report to any State or  
18 local agency, or, as of January 1, 2019, to  
19 the Secretary or any entity that is part of  
20 the Department of Health and Human  
21 Services, except data that are required  
22 under the programs terminated in section  
23 903.

24 (ii) Annual financial data that in-  
25 cludes information on employees (including

1 the number of employees, hours worked,  
2 and wage information) by job title and by  
3 each patient care unit or department with-  
4 in each facility (including outpatient units  
5 or departments); the number of registered  
6 nurses per staffed bed by each such unit or  
7 department; information on the dollar  
8 value and annual spending (including pur-  
9 chases, upgrades, and maintenance) for  
10 health information technology; and risk-ad-  
11 justed and raw patient outcome data (in-  
12 cluding data on medical, surgical, obstet-  
13 ric, and other procedures).

14 (C) REPORTS.—The Secretary shall regu-  
15 larly analyze information reported to the Sec-  
16 retary and shall define rules and procedures to  
17 allow researchers, scholars, health care pro-  
18 viders, and others to access and analyze data  
19 for purposes consistent with quality and out-  
20 comes research, without compromising patient  
21 privacy.

22 (2) ANNUAL REPORT.—Beginning 2 years after  
23 the date of the enactment of this Act, the Secretary  
24 shall annually report to Congress on the following:

1 (A) The status of implementation of the  
2 Act.

3 (B) Enrollment under this Act.

4 (C) Benefits under this Act.

5 (D) Expenditures and financing under this  
6 Act.

7 (E) Cost-containment measures and  
8 achievements under this Act.

9 (F) Quality assurance.

10 (G) Health care utilization patterns, in-  
11 cluding any changes attributable to the pro-  
12 gram.

13 (H) Changes in the per-capita costs of  
14 health care.

15 (I) Differences in the health status of the  
16 populations of the different States, including by  
17 racial, ethnic, national origin, primary language  
18 use, age, disability, sex, including gender iden-  
19 tity and sexual orientation, geographical, and  
20 income characteristics;

21 (J) Progress on quality and outcome meas-  
22 ures, and long-range plans and goals for  
23 achievements in such areas.

24 (K) Plans for improving service to medi-  
25 cally underserved populations.



1           (L) Transition problems as a result of im-  
2           plementation of this Act.

3           (M) Opportunities for improvements under  
4           this Act.

5           (3) STATISTICAL ANALYSES AND OTHER STUD-  
6           IES.—The Secretary may, either directly or by con-  
7           tract—

8           (A) make statistical and other studies, on  
9           a nationwide, regional, State, or local basis, of  
10          any aspect of the operation of this Act;

11          (B) develop and test methods of delivery of  
12          items and services as the Secretary may con-  
13          sider necessary or promising for the evaluation,  
14          or for the improvement, of the operation of this  
15          Act; and

16          (C) develop methodological standards for  
17          policymaking.

18          (c) AUDITS.—

19           (1) IN GENERAL.—The Comptroller General of  
20          the United States shall conduct an audit of the De-  
21          partment of Health and Human Services every fifth  
22          fiscal year following the effective date of this Act to  
23          determine the effectiveness of the program in car-  
24          rying out the duties under subsection (a).

1           (2) REPORTS.—The Comptroller General of the  
2           United States shall submit a report to Congress con-  
3           cerning the results of each audit conducted under  
4           this subsection.

5 **SEC. 402. CONSULTATION.**

6           The Secretary shall consult with Federal agencies,  
7           Indian tribes and urban Indian health organizations, and  
8           private entities, such as labor organizations representing  
9           health care workers, professional societies, national asso-  
10          ciations, nationally recognized associations of health care  
11          experts, medical schools and academic health centers, con-  
12          sumer groups, and business organizations in the formula-  
13          tion of guidelines, regulations, policy initiatives, and infor-  
14          mation gathering to ensure the broadest and most in-  
15          formed input in the administration of this Act. Nothing  
16          in this Act shall prevent the Secretary from adopting  
17          guidelines, consistent with the provisions of section 203(c),  
18          developed by such a private entity if, in the Secretary's  
19          judgment, such guidelines are generally accepted as rea-  
20          sonable and prudent and consistent with this Act.

21 **SEC. 403. REGIONAL ADMINISTRATION.**

22          (a) COORDINATION WITH REGIONAL OFFICES.—The  
23          Secretary shall establish and maintain regional offices for  
24          purposes of carrying out the duties specified in subsection  
25          (c) and promoting adequate access to, and efficient use

1 of, tertiary care facilities, equipment, and services by indi-  
2 viduals enrolled under this Act. Wherever possible, the  
3 Secretary shall incorporate regional offices of the Centers  
4 for Medicare & Medicaid Services for this purpose.

5 (b) APPOINTMENT OF REGIONAL DIRECTORS.—In  
6 each such regional office there shall be—

7 (1) one regional director appointed by the Sec-  
8 retary;

9 (2) one deputy director appointed by the re-  
10 gional director to represent the Indian and Alaska  
11 Native tribes in the region, if any; and

12 (3) one deputy director appointed by the re-  
13 gional director to oversee long-term services and  
14 supports.

15 (c) REGIONAL OFFICE DUTIES.—Each regional di-  
16 rector shall—

17 (1) provide an annual health care needs assess-  
18 ment with respect to the region under the director's  
19 jurisdiction to the Secretary after a thorough exam-  
20 ination of health needs and in consultation with pub-  
21 lic health officials, clinicians, patients, and patient  
22 advocates;

23 (2) recommend any changes in provider reim-  
24 bursement or payment for delivery of health services

1 determined appropriate by the regional director, sub-  
2 ject to the provisions of title VI; and

3 (3) establish a quality assurance mechanism in  
4 each such region in order to minimize both under-  
5 utilization and overutilization of health care items  
6 and services and to ensure that all providers meet  
7 quality standards established pursuant to this Act.

8 **SEC. 404. BENEFICIARY OMBUDSMAN.**

9 (a) IN GENERAL.—The Secretary shall appoint a  
10 Beneficiary Ombudsman who shall have expertise and ex-  
11 perience in the fields of health care and education of, and  
12 assistance to, individuals enrolled under this Act.

13 (b) DUTIES.—The Beneficiary Ombudsman shall—

14 (1) receive complaints, grievances, and requests  
15 for information submitted by individuals enrolled  
16 under this Act or eligible to enroll under this Act  
17 with respect to any aspect of the Medicare for All  
18 Program;

19 (2) provide assistance with respect to com-  
20 plaints, grievances, and requests referred to in para-  
21 graph (1), including assistance in collecting relevant  
22 information for such individuals, to seek an appeal  
23 of a decision or determination made by a regional of-  
24 fice or the Secretary; and



1 title XVIII or State plans under title XIX of the Social  
2 Security Act:

3 (1) Section 1128 (relating to exclusion of indi-  
4 viduals and entities).

5 (2) Section 1128A (civil monetary penalties).

6 (3) Section 1128B (criminal penalties).

7 (4) Section 1124 (relating to disclosure of own-  
8 ership and related information).

9 (5) Section 1126 (relating to disclosure of cer-  
10 tain owners).

11 (6) Section 1877 (relating to physician refer-  
12 rals).

## 13 **TITLE V—QUALITY ASSESSMENT**

### 14 **SEC. 501. QUALITY STANDARDS.**

15 (a) IN GENERAL.—All standards and quality meas-  
16 ures under this Act shall be implemented and evaluated  
17 by the Center for Clinical Standards and Quality of the  
18 Centers for Medicare & Medicaid Services (referred to in  
19 this title as the “Center”) or such other agency deter-  
20 mined appropriate by the Secretary, in coordination with  
21 the Agency for Healthcare Research and Quality and other  
22 offices of the Department of Health and Human Services.

23 (b) DUTIES OF THE CENTER.—The Center shall per-  
24 form the following duties:

1           (1) Review and evaluate each practice guideline  
2 developed under part B of title IX of the Public  
3 Health Service Act. In so reviewing and evaluating,  
4 the Center shall determine whether the guideline  
5 should be recognized as a national practice guideline  
6 in accordance with and subject to the provisions of  
7 section 203(c).

8           (2) Review and evaluate each standard of qual-  
9 ity, performance measure, and medical review cri-  
10 terion developed under part B of title IX of the Pub-  
11 lic Health Service Act (42 U.S.C. 299 et seq.). In  
12 so reviewing and evaluating, the Center shall deter-  
13 mine whether the standard, measure, or criterion is  
14 appropriate for use in assessing or reviewing the  
15 quality of items and services provided by health care  
16 institutions or health care professionals. The use of  
17 mechanisms that discriminate against people with  
18 disabilities is prohibited for use in any value or cost-  
19 effectiveness assessments. The Center shall consider  
20 the evidentiary basis for the standard, and the valid-  
21 ity, reliability, and feasibility of measuring the  
22 standard.

23           (3) Adoption of methodologies for profiling the  
24 patterns of practice of health care professionals and  
25 for identifying and notifying outliers.

1           (4) Development of minimum criteria for com-  
2           petence for entities that can qualify to conduct ongo-  
3           ing and continuous external quality reviews in the  
4           administrative regions. Such criteria shall require  
5           such an entity to be administratively independent of  
6           the individual or board that administers the region  
7           and shall ensure that such entities do not provide fi-  
8           nancial incentives to reviewers to favor one pattern  
9           of practice over another. The Center shall ensure co-  
10          ordination and reporting by such entities to ensure  
11          national consistency in quality standards.

12           (5) Submission of a report to the Secretary an-  
13          nually specifically on findings from outcomes re-  
14          search and development of practice guidelines that  
15          may affect the Secretary's determination of coverage  
16          of services under section 401(a)(1)(G).

17 **SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.**

18          (a)   EVALUATING   DATA   COLLECTION   AP-  
19   PROACHES.—The Center shall evaluate approaches for the  
20   collection of data under this Act, to be performed in con-  
21   junction with existing quality reporting requirements and  
22   programs under this Act, that allow for the ongoing, accu-  
23   rate, and timely collection of data on disparities in health  
24   care services and performance on the basis of race, eth-  
25   nicity, national origin, primary language use, age, dis-



1 ability, sex (including gender identity and sexual orienta-  
2 tion), geography, or socioeconomic status. In conducting  
3 such evaluation, the Center shall consider the following ob-  
4 jectives:

5 (1) Protecting patient privacy.

6 (2) Minimizing the administrative burdens of  
7 data collection and reporting on providers under this  
8 Act.

9 (3) Improving data on race, ethnicity, national  
10 origin, primary language use, age, disability, sex (in-  
11 cluding gender identity and sexual orientation), ge-  
12 ography, and socioeconomic status.

13 (b) REPORTS TO CONGRESS.—

14 (1) REPORT ON EVALUATION.—Not later than  
15 18 months after the date on which benefits first be-  
16 come available as described in section 106(a), the  
17 Center shall submit to Congress and the Secretary  
18 a report on the evaluation conducted under sub-  
19 section (a). Such report shall, taking into consider-  
20 ation the results of such evaluation—

21 (A) identify approaches (including defining  
22 methodologies) for identifying and collecting  
23 and evaluating data on health care disparities  
24 on the basis of race, ethnicity, national origin,  
25 primary language use, age, disability, sex (in-

1 including gender identity and sexual orientation),  
2 geography, or socioeconomic status under the  
3 Medicare for All Program; and

4 (B) include recommendations on the most  
5 effective strategies and approaches to reporting  
6 quality measures, as appropriate, on the basis  
7 of race, ethnicity, national origin, primary lan-  
8 guage use, age, disability, sex (including gender  
9 identity and sexual orientation), geography, or  
10 socioeconomic status.

11 (2) REPORT ON DATA ANALYSES.—Not later  
12 than 4 years after the submission of the report  
13 under subsection (b)(1), and every 4 years there-  
14 after, the Center shall submit to Congress and the  
15 Secretary a report that includes recommendations  
16 for improving the identification of health care dis-  
17 parities based on the analyses of data collected  
18 under subsection (c).

19 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not  
20 later than 2 years after the date on which benefits first  
21 become available as described in section 106(a), the Sec-  
22 retary shall implement the approaches identified in the re-  
23 port submitted under subsection (b)(1) for the ongoing,  
24 accurate, and timely collection and evaluation of data on  
25 health care disparities on the basis of race, ethnicity, na-

1 tional origin, primary language use, age, disability, sex  
2 (including gender identity and sexual orientation), geog-  
3 raphy, or socioeconomic status.

4 **TITLE VI—HEALTH BUDGET;**  
5 **PAYMENTS; COST CONTAIN-**  
6 **MENT MEASURES**

7 **Subtitle A—Budgeting**

8 **SEC. 601. NATIONAL HEALTH BUDGET.**

9 (a) NATIONAL HEALTH BUDGET.—

10 (1) IN GENERAL.—By not later than September  
11 1 of each year, beginning with the year prior to the  
12 date on which benefits first become available as de-  
13 scribed in section 106(a), the Secretary shall estab-  
14 lish a national health budget, which specifies a budg-  
15 et for the total expenditures to be made for covered  
16 health care items and services under this Act.

17 (2) DIVISION OF BUDGET INTO COMPONENTS.—

18 The national health budget shall consist of the fol-  
19 lowing components:

20 (A) An operating budget.

21 (B) A capital expenditures budget.

22 (C) A special projects budget.

23 (D) Quality assessment activities under  
24 title V.

1           (E) Health professional education expendi-  
2           tures.

3           (F) Administrative costs, including costs  
4           related to the operation of regional offices.

5           (G) A reserve fund.

6           (H) Prevention and public health activities.

7           (3) ALLOCATION AMONG COMPONENTS.—The  
8           Secretary shall allocate the funds received for pur-  
9           poses of carrying out this Act among the compo-  
10          nents described in paragraph (2) in a manner that  
11          ensures—

12           (A) that the operating budget allows for  
13           every participating provider in the Medicare for  
14           All Program to meet the needs of their respec-  
15           tive patient populations;

16           (B) that the special projects budget is suf-  
17           ficient to meet the health care needs within  
18           areas described in paragraph (2)(C) through  
19           the construction, renovation, and staffing of  
20           health care facilities in a reasonable timeframe;

21           (C) a fair allocation for quality assessment  
22           activities; and

23           (D) that the health professional education  
24           expenditure component is sufficient to provide  
25           for the amount of health professional education

1 expenditures sufficient to meet the need for cov-  
2 ered health care services.

3 (4) REGIONAL ALLOCATION.—The Secretary  
4 shall annually provide each regional office with an  
5 allotment the Secretary determines appropriate for  
6 purposes of carrying out this Act in such region, in-  
7 cluding payments to providers in such region, capital  
8 expenditures in such region, special projects in such  
9 region, health professional education in such region,  
10 administrative expenses in such region, and preven-  
11 tion and public health activities in such region.

12 (5) OPERATING BUDGET.—The operating budg-  
13 et described in paragraph (2)(A) shall be used for—

14 (A) payments to institutional providers  
15 pursuant to section 611; and

16 (B) payments to individual providers pur-  
17 suant to section 612.

18 (6) CAPITAL EXPENDITURES BUDGET.—The  
19 capital expenditures budget described in paragraph  
20 (2)(B) shall be used for—

21 (A) the construction or renovation of  
22 health care facilities, excluding congregate or  
23 segregated facilities for individuals with disabili-  
24 ties who receive long-term care services and  
25 support; and

1 (B) major equipment purchases.

2 (7) SPECIAL PROJECTS BUDGET.—The special  
3 projects budget described in paragraph (2)(C) shall  
4 be used for the purposes of allocating funds for the  
5 construction of new facilities, major equipment pur-  
6 chases, and staffing in rural or medically under-  
7 served areas (as defined in section 330(b)(3) of the  
8 Public Health Service Act (42 U.S.C. 254b(b)(3))),  
9 including areas designated as health professional  
10 shortage areas (as defined in section 332(a) of the  
11 Public Health Service Act (42 U.S.C. 254e(a))), and  
12 to address health disparities, including racial, ethnic,  
13 national origin, primary language use, age, dis-  
14 ability, sex (including gender identity and sexual ori-  
15 entation), geography, or socioeconomic health dis-  
16 parities.

17 (8) TEMPORARY WORKER ASSISTANCE.—

18 (A) IN GENERAL.—For up to 5 years fol-  
19 lowing the date on which benefits first become  
20 available as described in section 106(a), at least  
21 1 percent of the budget shall be allocated to  
22 programs providing assistance to workers who  
23 perform functions in the administration of the  
24 health insurance system, or related functions  
25 within health care institutions or organizations

1           who may be affected by the implementation of  
2           this Act and who may experience economic dis-  
3           location as a result of the implementation of  
4           this Act.

5                   (B) CLARIFICATION.—Assistance described  
6           in subparagraph (A) shall include wage replace-  
7           ment, retirement benefits, job training and  
8           placement, preferential hiring, and education  
9           benefits.

10           (9) RESERVE FUND.—The reserve fund de-  
11          scribed in paragraph (2)(G) shall be used to respond  
12          to the costs of an epidemic, pandemic, natural dis-  
13          aster, or other such health emergency, or market-  
14          shift adjustments related to patient volume.

15           (10) SUPPLEMENTAL INDIAN HEALTH SERVICE  
16          ALLOCATION.—The Secretary shall annually deter-  
17          mine the need to provide an allotment of supple-  
18          mental funds to Indian Health Services, including  
19          payments to providers, capital expenditures, special  
20          projects, health professional education, administra-  
21          tive expenses, and prevention and public health ac-  
22          tivities.

23          (b) DEFINITIONS.—In this section:

24                   (1) CAPITAL EXPENDITURES.—The term “cap-  
25          ital expenditures” means expenses for the purchase,

1 lease, construction, or renovation of capital facilities  
2 and for major equipment.

3 (2) HEALTH PROFESSIONAL EDUCATION EX-  
4 PENDITURES.—The term “health professional edu-  
5 cation expenditures” means expenditures in hospitals  
6 and other health care facilities to cover costs associ-  
7 ated with teaching and related research activities, in-  
8 cluding the impact of workforce diversity on patient  
9 outcomes.

## 10 **Subtitle B—Payments to Providers**

### 11 **SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS** 12 **BASED ON GLOBAL BUDGETS.**

13 (a) IN GENERAL.—Not later than the beginning of  
14 each fiscal quarter during which an institutional provider  
15 of care (including hospitals, skilled nursing facilities, Fed-  
16 erally qualified health centers, and independent dialysis fa-  
17 cilities) is to furnish items and services under this Act,  
18 the Secretary shall pay to such institutional provider a  
19 lump sum in accordance with the succeeding provisions of  
20 this subsection and consistent with the following:

21 (1) PAYMENT IN FULL.—Such payment shall be  
22 considered as payment in full for all operating ex-  
23 penses for items and services furnished under this  
24 Act, whether inpatient or outpatient, by such pro-  
25 vider for such quarter, including outpatient or any



1 other care provided by the institutional provider or  
2 provided by any health care provider who provided  
3 items and services pursuant to an agreement paid  
4 through the global budget as described in paragraph  
5 (3).

6 (2) QUARTERLY REVIEW.—The regional direc-  
7 tor, on a quarterly basis, shall review whether re-  
8 quirements of the institutional provider’s participa-  
9 tion agreement and negotiated global budget have  
10 been performed and shall determine whether adjust-  
11 ments to such institutional provider’s payment are  
12 warranted. This review shall include consideration  
13 for additional funding necessary for unanticipated  
14 items and services for individuals with complex med-  
15 ical needs or market-shift adjustments related to pa-  
16 tient volume. The review shall also include an as-  
17 sessment of any adjustments made to ensure that  
18 accuracy and need for adjustment was appropriate.

19 (3) AGREEMENTS FOR SALARIED PAYMENTS  
20 FOR CERTAIN PROVIDERS.—Certain group practices  
21 and other health care providers, as determined by  
22 the Secretary, with agreements to provide items and  
23 services at a specified institutional provider paid a  
24 global budget under this subsection may elect to be  
25 paid through such institutional provider’s global

1 budget in lieu of payment under section 612 of this  
2 title. Any—

3 (A) individual health care professional of  
4 such group practice or other provider receiving  
5 payment through an institutional provider's  
6 global budget shall be paid on a salaried basis  
7 that is equivalent to salaries or other compensa-  
8 tion rates negotiated for individual health care  
9 professionals of such institutional provider; and

10 (B) any group practice or other health care  
11 provider that receives payment through an in-  
12 stitutional provider global budget under this  
13 paragraph shall be subject to the same report-  
14 ing and disclosure requirements of the institu-  
15 tional provider.

16 (4) INTERIM ADJUSTMENTS.—The regional di-  
17 rector shall consider a petition for adjustment of any  
18 payment under this section filed by an institutional  
19 provider at any time based on the following:

20 (A) Factors that led to increased costs for  
21 the institutional provider that can reasonably be  
22 considered to be unanticipated and out of the  
23 control of the institutional provider, such as—

24 (i) natural disasters;

1 (ii) outbreaks of epidemics or infec-  
2 tious diseases;

3 (iii) unexpected facility or equipment  
4 repairs or purchases;

5 (iv) significant and unexpected in-  
6 creases in pharmaceutical or medical device  
7 prices; and

8 (v) unanticipated increases in complex  
9 or high-cost patients or care needs.

10 (B) Changes in Federal or State law that  
11 result in a change in costs.

12 (C) Reasonable increases in labor costs, in-  
13 cluding salaries and benefits, and changes in  
14 collective bargaining agreements, prevailing  
15 wage, or local law.

16 (b) PAYMENT AMOUNT.—

17 (1) IN GENERAL.—The amount of each pay-  
18 ment to a provider described in subsection (a) shall  
19 be determined before the start of each fiscal year  
20 through negotiations between the provider and the  
21 regional director with jurisdiction over such pro-  
22 vider. Such amount shall be based on factors speci-  
23 fied in paragraph (2).

1           (2) PAYMENT FACTORS.—Payments negotiated  
2 pursuant to paragraph (1) shall take into account,  
3 with respect to a provider—

4           (A) the historical volume of services pro-  
5 vided for each item and services in the previous  
6 3-year period;

7           (B) the actual expenditures of such pro-  
8 vider in such provider's most recent cost report  
9 under title XVIII of the Social Security Act for  
10 each item and service compared to—

11           (i) such expenditures for other institu-  
12 tional providers in the director's jurisdic-  
13 tion; and

14           (ii) normative payment rates estab-  
15 lished under comparative payment rate  
16 systems, including any adjustments, for  
17 such items and services;

18           (C) projected changes in the volume and  
19 type of items and services to be furnished;

20           (D) wages for employees, including any  
21 necessary increases mandatory minimum safe  
22 registered nurse-to-patient ratios and optimal  
23 staffing levels for physicians and other health  
24 care workers;

1 (E) the provider's maximum capacity to  
2 provide items and services;

3 (F) education and prevention programs;

4 (G) permissible adjustment to the pro-  
5 vider's operating budget due to factors such  
6 as—

7 (i) an increase in primary or specialty  
8 care access;

9 (ii) efforts to decrease health care dis-  
10 parities in rural or medically underserved  
11 areas;

12 (iii) a response to emergent epidemic  
13 conditions;

14 (iv) an increase in complex or high-  
15 cost patients or care needs; or

16 (v) proposed new and innovative pa-  
17 tient care programs at the institutional  
18 level;

19 (H) whether the provider is located in a  
20 high social vulnerability index community, zip  
21 code, or census track, or is a minority-serving  
22 provider; and

23 (I) any other factor determined appro-  
24 priate by the Secretary.

1           (3) LIMITATION.—Payment amounts negotiated  
2 pursuant to paragraph (1) may not—

3           (A) take into account capital expenditures  
4 of the provider or any other expenditure not di-  
5 rectly associated with the provision of items and  
6 services by the provider to an individual;

7           (B) be used by a provider for capital ex-  
8 penditures or such other expenditures;

9           (C) exceed the provider's capacity to pro-  
10 vide care under this Act; or

11           (D) be used to pay or otherwise com-  
12 pensate any board member, executive, or ad-  
13 ministrator of the institutional provider who  
14 has any interest or relationship prohibited  
15 under section 301(b)(2) of this Act or disclosed  
16 under section 301 of this Act.

17           (4) LIMITATION ON COMPENSATION.—Com-  
18 pensation costs for any employee or any contractor  
19 or any subcontractor employee of an institutional  
20 provider receiving global budgets under this section  
21 shall meet the compensation cap established in sec-  
22 tion 702 of the Bipartisan Budget Act of 2013 (41  
23 U.S.C. 4304(a)(16)) and implementing regulations.

24           (5) REGIONAL NEGOTIATIONS PERMITTED.—  
25 Subject to section 614, a regional director may nego-

1       tiate changes to an institutional provider's global  
2       budget, including any adjustments to address un-  
3       foreseen market-shifts related to patient volume.

4       (c) BASELINE RATES AND ADJUSTMENTS.—

5           (1) IN GENERAL.—The Secretary shall use ex-  
6       isting prospective payment systems under title  
7       XVIII of the Social Security Act to serve as the  
8       comparative payment rate system in global budget  
9       negotiations described in subsection (b). The Sec-  
10      retary shall update such comparative payment rate  
11      systems annually.

12          (2) SPECIFICATIONS.—In developing the com-  
13      parative payment rate system, the Secretary shall  
14      use only the operating base payment rates under  
15      each such prospective payment systems with applica-  
16      ble adjustments.

17          (3) LIMITATION.—The comparative rate system  
18      established under this subsection shall not include  
19      the value-based payment adjustments and the cap-  
20      ital expenses base payment rates that may be in-  
21      cluded in such a prospective payment system.

22          (4) INITIAL YEAR.—In the first year that global  
23      budget payments under this Act are available to in-  
24      stitutional providers and for purposes of selecting a  
25      comparative payment rate system used during initial

1 global budget negotiations for each institutional pro-  
2 vider, the Secretary shall take into account the ap-  
3 propriate prospective payment system from the most  
4 recent year under title XVIII of the Social Security  
5 Act to determine what operating base payment the  
6 institutional provider would have been paid for cov-  
7 ered items and services furnished the preceding year  
8 with applicable adjustments, excluding value-based  
9 payment adjustments, based on such prospective  
10 payment system.

11 (d) OPERATING EXPENSES.—For purposes of this  
12 title, “operating expenses” of a provider include the fol-  
13 lowing:

14 (1) The cost of all items and services associated  
15 with the provision of inpatient care and outpatient  
16 care, including the following:

17 (A) Wages and salary costs for physicians,  
18 nurses, and other health care practitioners em-  
19 ployed by an institutional provider, including  
20 mandatory minimum safe registered nurse-to-  
21 patient staffing ratios and optimal staffing lev-  
22 els for physicians and other healthcare workers.

23 (B) Wages and salary costs for all ancil-  
24 lary staff and services.



1           (C) Costs of all pharmaceutical products  
2 administered by health care clinicians at the in-  
3 stitutional provider's facilities or through serv-  
4 ices provided in accordance with State licensing  
5 laws or regulations under which the institu-  
6 tional provider operates.

7           (D) Costs for infectious disease response  
8 preparedness, including maintenance of a 1-  
9 year or 365-day stockpile of personal protective  
10 equipment, occupational testing and surveil-  
11 lance, medical services for occupational infec-  
12 tious disease exposure, and contact tracing.

13           (E) Purchasing and maintenance of med-  
14 ical devices, supplies, and other health care  
15 technologies, including diagnostic testing equip-  
16 ment.

17           (F) Costs of all incidental services nec-  
18 essary for safe patient care and handling.

19           (G) Costs of patient care, education, and  
20 prevention programs, including occupational  
21 health and safety programs, public health pro-  
22 grams, and necessary staff to implement such  
23 programs, for the continued education and  
24 health and safety of clinicians and other indi-  
25 viduals employed by the institutional provider.

1           (2) Administrative costs for the institutional  
2           provider.

3 **SEC. 612. PAYMENT TO INDIVIDUAL PROVIDERS THROUGH**  
4           **FEE-FOR-SERVICE.**

5           (a) IN GENERAL.—In the case of a provider not de-  
6           scribed in section 611(a) (including those in group prac-  
7           tices who are not receiving payment on a salaried basis  
8           described in section 611(a)(3) and providers of home and  
9           community-based services), payment for items and serv-  
10          ices furnished under this Act for which payment is not  
11          otherwise made under section 611 shall be made by the  
12          Secretary in amounts determined under the fee schedule  
13          established pursuant to subsection (b). Such payment  
14          shall be considered to be payment in full for such items  
15          and services, and a provider receiving such payment may  
16          not charge the individual receiving such item or service  
17          in any amount.

18          (b) FEE SCHEDULE.—

19               (1) ESTABLISHMENT.—Not later than 1 year  
20               after the date of the enactment of this Act, and in  
21               consultation with providers and regional office direc-  
22               tors, the Secretary shall establish a national fee  
23               schedule for items and services payable under this  
24               Act. The Secretary shall evaluate the effectiveness of

1 the fee-for-service structure and update such fee  
2 schedule annually.

3 (2) AMOUNTS.—In establishing payment  
4 amounts for items and services under the fee sched-  
5 ule established under paragraph (1), the Secretary  
6 shall take into account—

7 (A) the amounts payable for such items  
8 and services under title XVIII of the Social Se-  
9 curity Act; and

10 (B) the expertise of providers and value of  
11 items and services furnished by such providers.

12 (c) ELECTRONIC BILLING.—The Secretary shall es-  
13 tablish a uniform national system for electronic billing for  
14 purposes of making payments under this subsection.

15 (d) PHYSICIAN PRACTICE REVIEW BOARD.—Each di-  
16 rector of a regional office, in consultation with representa-  
17 tives of physicians practicing in that region, shall establish  
18 and appoint a physician practice review board to assure  
19 quality, cost effectiveness, and fair reimbursements for  
20 physician-delivered items and services. The use of mecha-  
21 nisms that discriminate against people with disabilities is  
22 prohibited for use in any value or cost-effectiveness assess-  
23 ments.

1 **SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES**  
2 **UNDER THE MEDICARE PHYSICIAN FEE**  
3 **SCHEDULE.**

4 (a) STANDARDIZED AND DOCUMENTED REVIEW  
5 PROCESS.—Section 1848(c)(2) of the Social Security Act  
6 (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the  
7 end the following new subparagraph:

8 “(P) STANDARDIZED AND DOCUMENTED  
9 REVIEW PROCESS.—

10 “(i) IN GENERAL.—Not later than one  
11 year after the date of enactment of this  
12 subparagraph, the Secretary shall estab-  
13 lish, document, and make publicly avail-  
14 able, in consultation with the Office of Pri-  
15 mary Health Care, a standardized process  
16 for reviewing the relative values of physi-  
17 cians’ services under this paragraph.

18 “(ii) MINIMUM REQUIREMENTS.—The  
19 standardized process shall include, at a  
20 minimum, methods and criteria for identi-  
21 fying services for review, prioritizing the  
22 review of services, reviewing stakeholder  
23 recommendations, and identifying addi-  
24 tional resources to be considered during  
25 the review process.”.

1 (b) PLANNED AND DOCUMENTED USE OF FUNDS.—  
2 Section 1848(c)(2)(M) of the Social Security Act (42  
3 U.S.C. 1395w-4(c)(2)(M)) is amended by adding at the  
4 end the following new clause:

5 “(x) PLANNED AND DOCUMENTED  
6 USE OF FUNDS.—For each fiscal year (be-  
7 ginning with the first fiscal year beginning  
8 on or after the date of enactment of this  
9 clause), the Secretary shall provide to Con-  
10 gress a written plan for using the funds  
11 provided under clause (ix) to collect and  
12 use information on physicians’ services in  
13 the determination of relative values under  
14 this subparagraph.”.

15 (c) INTERNAL TRACKING OF REVIEWS.—

16 (1) IN GENERAL.—Not later than 1 year after  
17 the date of enactment of this Act, the Secretary  
18 shall submit to Congress a proposed plan for system-  
19 atically and internally tracking the Secretary’s re-  
20 view of the relative values of physicians’ services,  
21 such as by establishing an internal database, under  
22 section 1848(c)(2) of the Social Security Act (42  
23 U.S.C. 1395w-4(c)(2)), as amended by this section.

24 (2) MINIMUM REQUIREMENTS.—The proposal  
25 shall include, at a minimum, plans and a timeline

1 for achieving the ability to systematically and inter-  
2 nally track the following:

3 (A) When, how, and by whom services are  
4 identified for review.

5 (B) When services are reviewed or re-  
6 viewed or when new services are added.

7 (C) The resources, evidence, data, and rec-  
8 ommendations used in reviews.

9 (D) When relative values are adjusted.

10 (E) The rationale for final relative value  
11 decisions.

12 (d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of  
13 the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is  
14 amended—

15 (1) in subparagraph (B)(i), by striking “5” and  
16 inserting “4”; and

17 (2) in subparagraph (K)(i)(I), by striking “peri-  
18 odically” and inserting “annually”.

19 (e) CONSULTATION WITH MEDICARE PAYMENT AD-  
20 VISORY COMMISSION.—

21 (1) IN GENERAL.—Section 1848(c)(2) of the  
22 Social Security Act (42 U.S.C. 1395w-4(c)(2)) is  
23 amended—

24 (A) in subparagraph (B)(i), by inserting  
25 “in consultation with the Medicare Payment

1           Advisory Commission,” after “The Secretary,”;  
2           and

3                   (B) in subparagraph (K)(i)(I), as amended  
4           by subsection (d)(2), by inserting “, in coordi-  
5           nation with the Medicare Payment Advisory  
6           Commission,” after “annually”.

7           (2) CONFORMING AMENDMENTS.—Section 1805  
8           of the Social Security Act (42 U.S.C. 1395b–6) is  
9           amended—

10                   (A) in subsection (b)(1)(A), by inserting  
11           the following before the semicolon at the end:  
12           “and including coordinating with the Secretary  
13           in accordance with section 1848(c)(2) to sys-  
14           tematically review the relative values established  
15           for physicians’ services, identify potentially  
16           misvalued services, and propose adjustments to  
17           the relative values for physicians’ services”; and

18                   (B) in subsection (e)(1), in the second sen-  
19           tence, by inserting “or the Ranking Minority  
20           Member” after “the Chairman”.

21           (f) PERIODIC AUDIT BY THE COMPTROLLER GEN-  
22           ERAL.—Section 1848(c)(2) of the Social Security Act (42  
23           U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is  
24           amended by adding at the end the following new subpara-  
25           graph:

1                   “(Q) PERIODIC AUDIT BY THE COMP-  
2                   TROLLER GENERAL.—

3                   “(i) IN GENERAL.—The Comptroller  
4                   General of the United States (in this sub-  
5                   section referred to as the ‘Comptroller  
6                   General’) shall periodically audit the review  
7                   by the Secretary of relative values estab-  
8                   lished under this paragraph for physicians’  
9                   services.

10                   “(ii) ACCESS TO INFORMATION.—The  
11                   Comptroller General shall have unre-  
12                   stricted access to all deliberations, records,  
13                   and data related to the activities carried  
14                   out under this paragraph, in a timely man-  
15                   ner, upon request.”.

16 **SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**  
17 **TURES; SPECIAL PROJECTS.**

18                   (a) SENSE OF CONGRESS.—It is the sense of Con-  
19                   gress that tens of millions of people in the United States  
20                   do not receive healthcare services while billions of dollars  
21                   that could be spent on providing health care are diverted  
22                   to profit. There is a moral imperative to correct the mas-  
23                   sive deficiencies in our current health system and to elimi-  
24                   nate profit from the provision of health care.



1 (b) PROHIBITIONS.—Payments to providers under  
2 this Act may not take into account, include any process  
3 for the provision of funding for, or be used by a provider  
4 for—

5 (1) marketing of the provider;

6 (2) the profit or net revenue of the provider, or  
7 increasing the profit or net revenue of the provider;

8 (3) incentive payments, bonuses, or other com-  
9 pensation based on patient utilization of items and  
10 services or any financial measure applied with re-  
11 spect to the provider (or any group practice, inte-  
12 grated health care delivery system, or other provider  
13 with which the provider contracts or has a pecuniary  
14 interest), including any value-based payment or em-  
15 ployment-based compensation;

16 (4) any agreement or arrangement described in  
17 section 203(a)(4) of the Labor-Management Report-  
18 ing and Disclosure Act of 1959 (29 U.S.C.  
19 433(a)(4)); or

20 (5) political or contributions prohibited under  
21 section 317 of the Federal Elections Campaign Act  
22 of 1971 (52 U.S.C. 30119(a)(1)).

23 (c) PAYMENTS FOR CAPITAL EXPENDITURES.—

24 (1) IN GENERAL.—The Secretary shall pay,  
25 from amounts made available for capital expendi-

1 tures pursuant to section 601(a)(2)(B), such sums  
2 determined appropriate by the Secretary to providers  
3 who have submitted an application to the regional  
4 director of the region or regions in which the pro-  
5 vider operates or seeks to operate in a time and  
6 manner specified by the Secretary for purposes of  
7 funding capital expenditures of such providers.

8 (2) PRIORITY.—The Secretary shall prioritize  
9 allocation of funding under paragraph (1) to  
10 projects that propose to use such funds to improve  
11 service in a medically underserved area (as defined  
12 in section 330(b)(3) of the Public Health Service  
13 Act (42 U.S.C. 254b(b)(3))) or to address health  
14 disparities, including racial, ethnic, national origin,  
15 primary language use, age, disability, sex (including  
16 gender identity and sexual orientation), geography,  
17 or socioeconomic health disparities.

18 (3) LIMITATION.—The Secretary shall not  
19 grant funding for capital expenditures under this  
20 subsection for capital projects that are financed di-  
21 rectly or indirectly through the diversion of private  
22 or other non-Medicare for All Program funding that  
23 results in reductions in care to patients, including  
24 reductions in registered nursing staffing patterns

1 and changes in emergency room or primary care  
2 services or availability.

3 (4) CAPITAL ASSETS NOT FUNDED BY THE  
4 MEDICARE FOR ALL PROGRAM.—Operating expenses  
5 and funds shall not be used by an institutional pro-  
6 vider receiving payment for capital expenditures  
7 under this subsection for a capital asset that was  
8 not funded by the Medicare for All program without  
9 the approval of the regional director or directors of  
10 the region or regions where the capital asset is lo-  
11 cated.

12 (d) PROHIBITION AGAINST CO-MINGLING OPER-  
13 ATING AND CAPITAL FUNDS.—Providers that receive pay-  
14 ment under this title shall be prohibited from using, with  
15 respect to funds made available under this Act—

16 (1) funds designated for operating expenditures  
17 for capital expenditures or for profit; or

18 (2) funds designated for capital expenditures  
19 for operating expenditures.

20 (e) PAYMENTS FOR SPECIAL PROJECTS.—

21 (1) IN GENERAL.—The Secretary shall allocate  
22 to each regional director, from amounts made avail-  
23 able for special projects pursuant to section  
24 601(a)(2)(C), such sums determined appropriate by  
25 the Secretary for purposes of funding projects de-

1 scribed in such section, including the construction,  
2 renovation, or staffing of health care facilities, in  
3 rural, underserved, or health professional or medical  
4 shortage areas within such region and to address  
5 health disparities, including racial, ethnic, national  
6 origin, primary language use, age, disability, sex, in-  
7 cluding gender identity and sexual orientation, geog-  
8 raphy, or socioeconomic health disparities. Each re-  
9 gional director shall, prior to distributing such funds  
10 in accordance with paragraph (2), present a budget  
11 describing how such funds will be distributed to the  
12 Secretary.

13 (2) DISTRIBUTION.—A regional director shall  
14 distribute funds to providers operating in the region  
15 of such director’s jurisdiction in a manner deter-  
16 mined appropriate by the director.

17 (f) PROHIBITION ON FINANCIAL INCENTIVE  
18 METRICS IN PAYMENT DETERMINATIONS.—The Sec-  
19 retary may not utilize any quality metrics or standards  
20 for the purposes of establishing provider payment meth-  
21 odologies, programs, modifiers, or adjustments for pro-  
22 vider payments under this title.

1 **SEC. 615. OFFICE OF HEALTH EQUITY.**

2 Title XVII of the Public Health Service Act (42  
3 U.S.C. 300u et seq.) is amended by adding at the end  
4 the following:

5 **“SEC. 1712. OFFICE OF HEALTH EQUITY.**

6 “(a) IN GENERAL.—There is established, in the Of-  
7 fice of the Secretary of Health and Human Services, an  
8 Office of Health Equity, to be headed by a Director, to  
9 ensure coordination and collaboration across the programs  
10 and activities of the Department of Health and Human  
11 Services with respect to ensuring health equity.

12 “(b) MONITORING, TRACKING, AND AVAILABILITY OF  
13 DATA.—

14 “(1) IN GENERAL.—In carrying out subsection  
15 (a), the Director of the Office of Health Equity shall  
16 monitor, track, and make publicly available data  
17 on—

18 “(A) the disproportionate burden of dis-  
19 ease and death among people of color,  
20 disaggregated by race, major ethnic group,  
21 Tribal affiliation, national origin, primary lan-  
22 guage use, English proficiency status, immigra-  
23 tion status, length of stay in the United States  
24 age, disability, sex (including gender identity  
25 and sexual orientation), incarceration, home-  
26 lessness, geography, and socioeconomic status;

1           “(B) barriers to health, including such  
2 barriers relating to income, education, housing,  
3 food insecurity (including availability, access,  
4 utilization, and stability), employment status,  
5 working conditions, and conditions related to  
6 the physical environment (including pollutants  
7 and population density);

8           “(C) barriers to health care access, includ-  
9 ing—

10                   “(i) lack of trust and awareness;

11                   “(ii) lack of transportation;

12                   “(iii) geography;

13                   “(iv) hospital and service closures;

14                   “(v) lack of health care infrastructure  
15 and facilities; and

16                   “(vi) lack of health care professional  
17 staffing and recruitment;

18           “(D) disparities in quality of care received,  
19 including discrimination in health care settings  
20 and the use of racially-biased practice guide-  
21 lines and algorithms; and

22                   “(E) disparities in utilization of care.

23           “(2) ANALYSIS OF CROSS-SECTIONAL INFORMA-  
24 TION.—The Director of the Office of Health Equity  
25 shall ensure that the data collection and reporting

1 process under paragraph (1) allows for the analysis  
2 of cross-sectional information on people’s identities.

3 “(c) POLICIES.—In carrying out subsection (a), the  
4 Director of the Office of Health Equity shall develop, co-  
5 ordinate, and promote policies that enhance health equity,  
6 including by—

7 “(1) providing recommendations on—

8 “(A) cultural competence, implicit bias,  
9 and ethics training with respect to health care  
10 workers;

11 “(B) increasing diversity in the health care  
12 workforce; and

13 “(C) ensuring sufficient health care profes-  
14 sionals and facilities; and

15 “(2) ensuring adequate public health funding at  
16 the local and State levels to address health dispari-  
17 ties.

18 “(d) CONSULTATION.—In carrying out subsection  
19 (a), the Director of the Office of Health Equity, in coordi-  
20 nation with the Director of the Indian Health Service,  
21 shall consult with Indian Tribes and with Urban Indian  
22 organizations on data collection, reporting, and implemen-  
23 tation of policies.

1       “(e) ANNUAL REPORT.—In carrying out subsection  
2 (a), the Director of the Office of Health Equity shall de-  
3 velop and publish an annual report on—

4               “(1) statistics collected by the Office;

5               “(2) proposed evidence-based solutions to miti-  
6 gate health inequities; and

7               “(3) health care professional staffing levels and  
8 access to facilities.

9       “(f) CENTRALIZED ELECTRONIC REPOSITORY.—In  
10 carrying out subsection (a), the Director of the Office of  
11 Health Equity shall—

12               “(1) establish and maintain a centralized elec-  
13 tronic repository to incorporate data collected across  
14 Federal departments and agencies on race, ethnicity,  
15 Tribal affiliation, national origin, primary language  
16 use, English proficiency status, immigration status,  
17 length of stay in the United States age, disability,  
18 sex (including gender identity and sexual orienta-  
19 tion), incarceration, homelessness, geography, and  
20 socioeconomic status; and

21               “(2) make such data available for public use  
22 and analysis.

23       “(g) PRIVACY.—Notwithstanding any other Federal  
24 or State law, no Federal or State official or employee or  
25 other entity shall disclose, or use, for any law enforcement



1 or immigration purpose, any personally identifiable infor-  
2 mation (including with respect to an individual’s religious  
3 beliefs, practices, or affiliation, national origin, ethnicity,  
4 or immigration status) that is collected or maintained pur-  
5 suant to this section.”.

6 **SEC. 616. OFFICE OF PRIMARY CARE.**

7 Title XVII of the Public Health Service Act (42  
8 U.S.C. 300u et seq.) is amended by adding at the end  
9 the following:

10 **“SEC. 1713. OFFICE OF PRIMARY CARE.**

11 “(a) IN GENERAL.—There is established, in the Of-  
12 fice of Health Equity established under section 1712, an  
13 Office of Primary Health Care, to be headed by a Direc-  
14 tor, to ensure coordination and collaboration across the  
15 programs and activities of the Department of Health and  
16 Human Services with respect to increasing access to high-  
17 quality primary health care, particularly in underserved  
18 areas and for underserved populations.

19 “(b) NATIONAL GOALS.—Not later than 1 year after  
20 the date of enactment of this section, the Director of the  
21 Office of Primary Health Care shall publish national  
22 goals—

23 “(1) to increase access to high-quality primary  
24 health care, particularly in underserved areas and  
25 for underserved populations; and

1           “(2) to address health disparities, including  
2 with respect to race, ethnicity, national origin  
3 (disaggregated by major ethnic group and Tribal af-  
4 filiation), primary language use, English proficiency  
5 status, immigration status, length of stay in the  
6 United States, age, disability, sex (including gender  
7 identity and sexual orientation), incarceration, home-  
8 lessness, geography, and socioeconomic status.

9           “(c) OTHER RESPONSIBILITIES.—In carrying out  
10 subsections (a) and (b), the Director of the Office of Pri-  
11 mary Health Care shall—

12           “(1) coordinate, in consultation with the Sec-  
13 retary, health professional education policies and  
14 goals to achieve the national goals published pursu-  
15 ant to subsection (b);

16           “(2) develop and maintain a system to monitor  
17 the number and specialties of individuals pursuing  
18 careers in, or practicing, primary health care  
19 through their health professional education, any  
20 postgraduate training, and professional practice;

21           “(3) develop, coordinate, and promote policies  
22 that expand the number of primary health care prac-  
23 titioners, registered nurses, mid-level practitioners,  
24 and dentists;

1           “(4) recommend appropriate training, technical  
2           assistance, and patient protection enhancements for  
3           primary care health professionals, including reg-  
4           istered nurses, to achieve uniform high quality and  
5           patient safety;

6           “(5) provide recommendations on targeted pro-  
7           grams and resources for Federally qualified health  
8           centers, rural health centers, community health cen-  
9           ters, and other community-based organizations;

10          “(6) provide recommendations for broader pa-  
11          tient referral to additional resources, not limited to  
12          health care, and collaboration with other organiza-  
13          tions and sectors that influence health outcomes;  
14          and

15          “(7) consult with the Secretary on the alloca-  
16          tion of the special projects budget under section  
17          601(a)(2)(C) of the Medicare for All Act of 2021.

18          “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
19          tion shall be construed—

20                 “(1) to preempt any provision of State law es-  
21                 tablishing practice standards or guidelines for health  
22                 care professionals, including professional licensing or  
23                 practice laws or regulations; or

1           “(2) to require that any State impose additional  
2           educational standards or guidelines for health care  
3           professionals.”.

4 **SEC. 617. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**  
5 **PROVED DEVICES AND EQUIPMENT.**

6           The prices to be paid for covered pharmaceuticals,  
7           medical supplies, medical technologies, and medically nec-  
8           essary equipment covered under this Act shall be nego-  
9           tiated annually by the Secretary.

10           (1) IN GENERAL.—Notwithstanding any other  
11           provision of law, the Secretary shall, for fiscal years  
12           beginning on or after the date of the enactment of  
13           this subsection, negotiate with pharmaceutical man-  
14           ufacturers the prices (including discounts, rebates,  
15           and other price concessions) that may be charged to  
16           the Medicare for All Program during a negotiated  
17           price period (as specified by the Secretary) for cov-  
18           ered drugs for eligible individuals under the Medi-  
19           care for All Program. In negotiating such prices  
20           under this section, the Secretary shall take into ac-  
21           count the following factors:

22                   (A) The comparative clinical effectiveness  
23                   and cost effectiveness, when available from an  
24                   impartial source, of such drug.

1           (B) The budgetary impact of providing  
2 coverage of such drug.

3           (C) The number of similarly effective  
4 drugs or alternative treatment regimens for  
5 each approved use of such drug.

6           (D) The total revenues from global sales  
7 obtained by the manufacturer for such drug  
8 and the associated investment in research and  
9 development of such drug by the manufacturer.

10           (2) FINALIZATION OF NEGOTIATED PRICE.—

11           The negotiated price of each covered drug for a ne-  
12 gotiated price period shall be finalized not later than  
13 30 days before the first fiscal year in such nego-  
14 tiated price period.

15           (3) COMPETITIVE LICENSING AUTHORITY.—

16           (A) IN GENERAL.—Notwithstanding any  
17 exclusivity under clause (iii) or (iv) of section  
18 505(j)(5)(F) of the Federal Food, Drug, and  
19 Cosmetic Act, clause (iii) or (iv) of section  
20 505(c)(3)(E) of such Act, section 351(k)(7)(A)  
21 of the Public Health Service Act, or section  
22 527(a) of the Federal Food, Drug, and Cos-  
23 metic Act, or by an extension of such exclusivity  
24 under section 505A of such Act or section 505E  
25 of such Act, and any other provision of law that

1 provides for market exclusivity (or extension of  
2 market exclusivity) with respect to a drug, in  
3 the case that the Secretary is unable to success  
4 fully negotiate an appropriate price for a cov-  
5 ered drug for a negotiated price period, the Sec-  
6 retary shall authorize the use of any patent,  
7 clinical trial data, or other exclusivity granted  
8 by the Federal Government with respect to such  
9 drug as the Secretary determines appropriate  
10 for purposes of manufacturing such drug for  
11 sale under Medicare for All Program. Any enti-  
12 ty making use of a competitive license to use  
13 patent, clinical trial data, or other exclusivity  
14 under this section shall provide to the manufac-  
15 turer holding such exclusivity reasonable com-  
16 pensation, as determined by the Secretary  
17 based on the following factors:

18 (i) The risk-adjusted value of any  
19 Federal Government subsidies and invest-  
20 ments in research and development used to  
21 support the development of such drug.

22 (ii) The risk-adjusted value of any in-  
23 vestment made by such manufacturer in  
24 the research and development of such  
25 drug.

1 (iii) The impact of the price, including  
2 license compensation payments, on meeting  
3 the medical need of all patients at a rea-  
4 sonable cost.

5 (iv) The relationship between the  
6 price of such drug, including compensation  
7 payments, and the health benefits of such  
8 drug.

9 (v) Other relevant factors determined  
10 appropriate by the Secretary to provide  
11 reasonable compensation.

12 (B) REASONABLE COMPENSATION.—The  
13 manufacturer described in subparagraph (A)  
14 may seek recovery against the United States in  
15 the United States Court of Federal Claims.

16 (C) INTERIM PERIOD.—Until 1 year after  
17 a drug described in subparagraph (A) is ap-  
18 proved under section 505(j) of the Federal  
19 Food, Drug, and Cosmetic Act or section  
20 351(k) of the Public Health Service Act and is  
21 provided under license issued by the Secretary  
22 under such subparagraph, the Medicare for All  
23 Program shall not pay more for such drug than  
24 the average of the prices available, during the  
25 most recent 12-month period for which data is

1 available prior to the beginning of such nego-  
2 tiated price period, from the manufacturer to  
3 any wholesaler, retailer, provider, health main-  
4 tenance organization, nonprofit entity, or gov-  
5 ernmental entity in the ten OECD (Organiza-  
6 tion for Economic Cooperation and Develop-  
7 ment) countries that have the largest gross do-  
8 mestic product with a per capita income that is  
9 not less than half the per capita income of the  
10 United States.

11 (D) AUTHORIZATION FOR SECRETARY TO  
12 PROCURE DRUGS DIRECTLY.—The Secretary  
13 may procure a drug manufactured pursuant to  
14 a competitive license under subparagraph (A)  
15 for purposes of this Act.

16 (4) FDA REVIEW OF LICENSED DRUG APPLICA-  
17 TIONS.—The Secretary shall prioritize review of ap-  
18 plications under section 505(j) of the Federal Food,  
19 Drug, and Cosmetic Act for drugs licensed under  
20 paragraph (3)(A).

21 (5) PROHIBITION OF ANTICOMPETITIVE BEHAV-  
22 IOR.—No drug manufacturer may engage in anti-  
23 competitive behavior with another manufacturer that  
24 may interfere with the issuance and implementation



1 of a competitive license or run contrary to public  
2 policy.

3 (6) REQUIRED REPORTING.—The Secretary  
4 may require pharmaceutical manufacturers to dis-  
5 close to the Secretary such information that the Sec-  
6 retary determines necessary for purposes of carrying  
7 out this subsection.

8 **TITLE VII—UNIVERSAL**  
9 **MEDICARE TRUST FUND**

10 **SEC. 701. UNIVERSAL MEDICARE TRUST FUND.**

11 (a) IN GENERAL.—There is hereby created on the  
12 books of the Treasury of the United States a trust fund  
13 to be known as the Universal Medicare Trust Fund (in  
14 this section referred to as the “Trust Fund”). The Trust  
15 Fund shall consist of such gifts and bequests as may be  
16 made and such amounts as may be deposited in, or appro-  
17 priated to, such Trust Fund as provided in this Act.

18 (b) APPROPRIATIONS INTO TRUST FUND.—

19 (1) TAXES.—There are appropriated to the  
20 Trust Fund for each fiscal year beginning with the  
21 fiscal year which includes the date on which benefits  
22 first become available as described in section 106,  
23 out of any moneys in the Treasury not otherwise ap-  
24 propriated, amounts equivalent to 100 percent of the  
25 net increase in revenues to the Treasury which is at-

1       tributable to the amendments made by sections 801  
2       and 902. The amounts appropriated by the pre-  
3       ceding sentence shall be transferred from time to  
4       time (but not less frequently than monthly) from the  
5       general fund in the Treasury to the Trust Fund,  
6       such amounts to be determined on the basis of esti-  
7       mates by the Secretary of the Treasury of the taxes  
8       paid to or deposited into the Treasury, and proper  
9       adjustments shall be made in amounts subsequently  
10      transferred to the extent prior estimates were in ex-  
11      cess of or were less than the amounts that should  
12      have been so transferred.

13               (2) CURRENT PROGRAM RECEIPTS.—

14               (A) INITIAL YEAR.—Notwithstanding any  
15               other provision of law, there is appropriated to  
16               the Trust Fund for the fiscal year containing  
17               January 1 of the first year following the date  
18               of the enactment of this Act, an amount equal  
19               to the aggregate amount appropriated for the  
20               preceding fiscal year for the following (in-  
21               creased by the consumer price index for all  
22               urban consumers for the fiscal year involved):

23                       (i) The Medicare program under title  
24                       XVIII of the Social Security Act (other

1 than amounts attributable to any pre-  
2 miums under such title).

3 (ii) The Medicaid program under  
4 State plans approved under title XIX of  
5 such Act.

6 (iii) The Federal Employees Health  
7 Benefits program, under chapter 89 of title  
8 5, United States Code.

9 (iv) The purchased care component of  
10 the TRICARE program, under chapter 55  
11 of title 10, United States Code (other than  
12 amounts appropriated for the purchased  
13 care component of the TRICARE Overseas  
14 Program).

15 (v) The maternal and child health  
16 program (under title V of the Social Secu-  
17 rity Act), vocational rehabilitation pro-  
18 grams, programs for drug abuse and men-  
19 tal health services under the Public Health  
20 Service Act, programs providing general  
21 hospital or medical assistance, and any  
22 other Federal program identified by the  
23 Secretary, in consultation with the Sec-  
24 retary of the Treasury, to the extent the  
25 programs provide for payment for health

1 services the payment of which may be  
2 made under this Act.

3 (B) SUBSEQUENT YEARS.—Notwithstand-  
4 ing any other provision of law, there is appro-  
5 priated to the trust fund for the fiscal year con-  
6 taining January 1 of the second year following  
7 the date of the enactment of this Act, and for  
8 each fiscal year thereafter, an amount equal to  
9 the amount appropriated to the Trust Fund for  
10 the previous year, adjusted for reductions in  
11 costs resulting from the implementation of this  
12 Act, changes in the consumer price index for all  
13 urban consumers for the fiscal year involved,  
14 and other factors determined appropriate by the  
15 Secretary.

16 (3) RESTRICTIONS SHALL NOT APPLY.—Any  
17 other provision of law in effect on the date of enact-  
18 ment of this Act restricting the use of Federal funds  
19 for any reproductive health service shall not apply to  
20 monies in the Trust Fund.

21 (c) INCORPORATION OF PROVISIONS.—The provisions  
22 of subsections (b) through (i) of section 1817 of the Social  
23 Security Act (42 U.S.C. 1395i) shall apply to the Trust  
24 Fund under this section in the same manner as such pro-  
25 visions applied to the Federal Hospital Insurance Trust

1 Fund under such section 1817, except that, for purposes  
 2 of applying such subsections to this section, the “Board  
 3 of Trustees of the Trust Fund” shall mean the “Sec-  
 4 retary”.

5 (d) TRANSFER OF FUNDS.—Any amounts remaining  
 6 in the Federal Hospital Insurance Trust Fund under sec-  
 7 tion 1817 of the Social Security Act (42 U.S.C. 1395i)  
 8 or the Federal Supplementary Medical Insurance Trust  
 9 Fund under section 1841 of such Act (42 U.S.C. 1395t)  
 10 after the payment of claims for items and services fur-  
 11 nished under title XVIII of such Act have been completed,  
 12 shall be transferred into the Universal Medicare Trust  
 13 Fund under this section.

14 **TITLE VIII—CONFORMING**  
 15 **AMENDMENTS TO THE EM-**  
 16 **PLOYEE RETIREMENT IN-**  
 17 **COME SECURITY ACT OF 1974**

18 **SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**  
 19 **TIVE OF BENEFITS UNDER THE MEDICARE**  
 20 **FOR ALL PROGRAM; COORDINATION IN CASE**  
 21 **OF WORKERS' COMPENSATION.**

22 (a) IN GENERAL.—Part 5 of subtitle B of title I of  
 23 the Employee Retirement Income Security Act of 1974  
 24 (29 U.S.C. 1131 et seq.) is amended by adding at the end  
 25 the following new section:

1 **“SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**  
2 **CATIVE OF UNIVERSAL MEDICARE PROGRAM**  
3 **BENEFITS; COORDINATION IN CASE OF**  
4 **WORKERS’ COMPENSATION.**

5 “(a) IN GENERAL.—Subject to subsection (b), no em-  
6 ployee benefit plan may provide benefits that duplicate  
7 payment for any items or services for which payment may  
8 be made under the Medicare for All Act of 2021.

9 “(b) REIMBURSEMENT.—Each workers compensation  
10 carrier that is liable for payment for workers compensa-  
11 tion services furnished in a State shall reimburse the  
12 Medicare for All Program for the cost of such services.

13 “(c) DEFINITIONS.—In this subsection—

14 “(1) the term ‘workers compensation carrier’  
15 means an insurance company that underwrite work-  
16 ers compensation medical benefits with respect to  
17 one or more employers and includes an employer or  
18 fund that is financially at risk for the provision of  
19 workers compensation medical benefits;

20 “(2) the term ‘workers compensation medical  
21 benefits’ means, with respect to an enrollee who is  
22 an employee subject to the workers compensation  
23 laws of a State, the comprehensive medical benefits  
24 for work-related injuries and illnesses provided for  
25 under such laws with respect to such an employee;  
26 and



1 payments for any items or services for which payment may  
2 be made under the this Act.

3 (b) CONFORMING AMENDMENT.—Section 601 of part  
4 6 of subtitle B of title I of the Employee Retirement In-  
5 come Security Act of 1974 (19 U.S.C. 1161) is amended  
6 by adding the following subsection at the end:

7 “(c) Subsection (a) shall apply to any group health  
8 plan that does not duplicate payments for any items or  
9 services for which payment may be made under the Medi-  
10 care for All Act of 2021.”.

11 **SEC. 803. EFFECTIVE DATE OF TITLE.**

12 The provisions of and amendments made by this title  
13 shall take effect on the date described in section 106(a).

14 **TITLE IX—ADDITIONAL**  
15 **CONFORMING AMENDMENTS**

16 **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**  
17 **PROGRAMS.**

18 (a) MEDICARE, MEDICAID, AND STATE CHILDREN’S  
19 HEALTH INSURANCE PROGRAM (SCHIP).—

20 (1) IN GENERAL.—Notwithstanding any other  
21 provision of law and with respect to an individual el-  
22 igible to enroll under this Act, subject to paragraphs  
23 (2) and (3)—

24 (A) no benefits shall be available under  
25 title XVIII of the Social Security Act for any



1 item or service furnished beginning on the date  
2 that is 2 years after the date of the enactment  
3 of this Act;

4 (B) no individual is entitled to medical as-  
5 sistance under a State plan approved under  
6 title XIX of such Act for any item or service  
7 furnished on or after such date;

8 (C) no individual is entitled to medical as-  
9 sistance under a State child health plan under  
10 title XXI of such Act for any item or service  
11 furnished on or after such date; and

12 (D) no payment shall be made to a State  
13 under section 1903(a) or 2105(a) of such Act  
14 with respect to medical assistance or child  
15 health assistance for any item or service fur-  
16 nished on or after such date.

17 (2) TRANSITION.—In the case of inpatient hos-  
18 pital services and extended care services during a  
19 continuous period of stay which began before the ef-  
20 fective date of benefits under section 106, and which  
21 had not ended as of such date, for which benefits  
22 are provided under title XVIII of the Social Security  
23 Act, under a State plan under title XIX of such Act,  
24 or under a State child health plan under title XXI  
25 of such Act, the Secretary shall provide for continu-

1       ation of benefits under such title or plan until the  
2       end of the period of stay.

3           (3) SCHOOL PROGRAMS.—All school related  
4       health programs, centers, initiatives, services, or  
5       other activities or work provided under title XIX or  
6       title XXI of the Social Security Act as of January  
7       1, 2019, shall be continued and covered by the Medi-  
8       care for All Program.

9           (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-  
10       GRAM.—No benefits shall be made available under chapter  
11       89 of title 5, United States Code, with respect to items  
12       and services furnished to any individual eligible to enroll  
13       under this Act.

14          (c) TRICARE PROGRAM.—

15           (1) DIRECT CARE COMPONENT.—Nothing in  
16       this Act shall affect the eligibility of beneficiaries  
17       under chapter 55 of title 10, United States Code,  
18       who are entitled to receive care furnished at facilities  
19       of the uniformed services under the TRICARE pro-  
20       gram for such care.

21           (2) PURCHASED CARE COMPONENT.—

22           (A) IN GENERAL.—Except as provided in  
23       subparagraph (B), no benefits shall be made  
24       available under the purchased care component  
25       of the TRICARE program for items or services

1 furnished to any individual eligible to enroll  
2 under this Act.

3 (B) TRICARE OVERSEAS.—During any  
4 period in which an individual is eligible for ben-  
5 efits under the TRICARE Overseas Program  
6 and is located in a TRICARE overseas region,  
7 the individual may receive benefits for items or  
8 services furnished to the individual under the  
9 purchased care component of such program  
10 during such period.

11 (d) TREATMENT OF BENEFITS FOR VETERANS AND  
12 NATIVE AMERICANS.—

13 (1) IN GENERAL.—Nothing in this Act shall af-  
14 fect the eligibility of veterans for the medical bene-  
15 fits and services provided under title 38, United  
16 States Code, or of Indians for the medical benefits  
17 and services provided by or through the Indian  
18 Health Service.

19 (2) REEVALUATION.—No reevaluation of the  
20 Indian Health Service shall be undertaken without  
21 consultation with tribal leaders and stakeholders.

22 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**  
23 **EXCHANGES.**

24 Effective on the date that is 2 years after the date  
25 of the enactment of this Act, the Federal and State Ex-

1 changes established pursuant to title I of the Patient Pro-  
2 tection and Affordable Care Act (Public Law 111–148)  
3 shall terminate, and any other provision of law that relies  
4 upon participation in or enrollment through such an Ex-  
5 change, including such provisions of the Internal Revenue  
6 Code of 1986, shall cease to have force or effect.

7 **SEC. 903. SUNSET OF PROVISIONS RELATED TO PAY FOR**  
8 **PERFORMANCE PROGRAMS.**

9 (a) Effective on the date described in section 106(a),  
10 the Federal programs related to pay for performance pro-  
11 grams and value-based purchasing shall terminate, and  
12 any other provision of law that relies upon participation  
13 in or enrollment in such program shall cease to have force  
14 or effect. Programs that shall terminate include—

15 (1) the Merit-based Incentive Payment System  
16 established pursuant to subsection (q) of section  
17 1848 of the Social Security Act (42 U.S.C. 1395w–  
18 4(q));

19 (2) the incentives for meaningful use of cer-  
20 tified EHR technology established pursuant to sub-  
21 section (a)(7) of section 1848 of the Social Security  
22 Act (42 U.S.C. 1395w–4(a)(7));

23 (3) the incentives for adoption and meaningful  
24 use of certified EHR technology established pursu-

1 ant to subsection (o) of section 1848 of the Social  
2 Security Act (42 U.S.C. 1395w-4(o));

3 (4) alternative payment models established  
4 under section 1833(z) of the Social Security Act (42  
5 U.S.C. 1395(z)); and

6 (5) the following programs as established pur-  
7 suant to the following sections of the Patient Protec-  
8 tion and Affordable Care Act:

9 (A) Section 2701 (adult health quality  
10 measures).

11 (B) Section 2702 (payment adjustments  
12 for health care acquired conditions).

13 (C) Section 2706 (Pediatric Accountable  
14 Care Organization Demonstration Projects for  
15 the purposes of receiving incentive payments).

16 (D) Section 3002(b) (42 U.S.C. 1395w-  
17 4(a)(8)) (incentive payments for quality report-  
18 ing).

19 (E) Section 3001(a) (42 U.S.C.  
20 1395ww(o)) (Hospital Value-Based Purchas-  
21 ing).

22 (F) Section 3006 (value-based purchasing  
23 program for skilled nursing facilities and home  
24 health agencies).

1 (G) Section 3007 (42 U.S.C. 1395w-4(p))  
2 (value based payment modifier under physician  
3 fee schedule).

4 (H) Section 3008 (42 U.S.C. 1395ww(p))  
5 (payment adjustments for health care-acquired  
6 condition).

7 (I) Section 3022 (42 U.S.C. 1395jjj)  
8 (Medicare shared savings programs).

9 (J) Section 3023 (42 U.S.C. 1395cc-4)  
10 (National Pilot Program on Payment Bun-  
11 dling).

12 (K) Section 3024 (42 U.S.C. 1395cc-5)  
13 (Independence at home demonstration pro-  
14 gram).

15 (L) Section 3025 (42 U.S.C. 1395ww(q))  
16 (hospital readmissions reduction program).

17 (M) Section 10301 (plans for value-based  
18 purchasing program for ambulatory surgical  
19 centers).

1                   **TITLE X—TRANSITION**  
2   **Subtitle A—Medicare for All Tran-**  
3   **sition Over 2 Years and Transi-**  
4   **tional Buy-In Option**

5   **SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO**  
6                   **YEARS.**

7           Title XVIII of the Social Security Act (42 U.S.C.  
8   1395c et seq.) is amended by adding at the end the fol-  
9   lowing new section:

10 **“SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2**  
11                   **YEARS.**

12           “(a) **TRANSITION.—**

13                   “(1) **IN GENERAL.—**Every individual who meets  
14           the requirements described in paragraph (3) shall be  
15           eligible to enroll in the Medicare for All Program  
16           under this section during the transition period start-  
17           ing one year after the date of enactment of the  
18           Medicare for All Act of 2021.

19                   “(2) **BENEFITS.—**An individual enrolled under  
20           this section is entitled to the benefits established  
21           under title II of the Medicare for All Act of 2021.

22                   “(3) **REQUIREMENTS FOR ELIGIBILITY.—**The  
23           requirements described in this paragraph are the fol-  
24           lowing:

1           “(A) The individual meets the eligibility re-  
2           quirements established by the Secretary under  
3           title I of the Medicare for All Act of 2021.

4           “(B) The individual has attained the appli-  
5           cable year of age, or is currently enrolled in  
6           Medicare at the time of the transition to Medi-  
7           care for All.

8           “(4) APPLICABLE YEAR OF AGE DEFINED.—  
9           For purposes of this section, the term ‘applicable  
10          year of age’ means one year after the date of enact-  
11          ment of the Medicare for All Act of 2021, the age  
12          of 55 or older, the age 18 or younger.

13          “(b) ENROLLMENT; COVERAGE.—The Secretary shall  
14          establish enrollment periods and coverage under this sec-  
15          tion consistent with the principles for establishment of en-  
16          rollment periods and coverage for individuals under other  
17          provisions of this title. The Secretary shall establish such  
18          periods so that coverage under this section shall first begin  
19          on January 1 of the year on which an individual first be-  
20          comes eligible to enroll under this section.

21          “(c) SATISFACTION OF INDIVIDUAL MANDATE.—For  
22          purposes of applying section 5000A of the Internal Rev-  
23          enue Code of 1986, the coverage provided under this sec-  
24          tion constitutes minimum essential coverage under sub-  
25          section (f)(1)(A)(i) of such section 5000A.





1 of the Patient Protection and Affordable Care Act  
2 (and the amendments made by that title) and title  
3 XXVII of the Public Health Service Act (42 U.S.C.  
4 300gg et seq.) that are applicable to qualified health  
5 plans offered through the Exchanges, subject to the  
6 limitation under subsection (e)(2).

7 (3) OFFERING THROUGH EXCHANGES.—The  
8 Medicare Transition buy-in shall be made available  
9 only through the Exchanges, and shall be available  
10 to individuals wishing to enroll and to qualified em-  
11 ployers (as defined in section 1312(f)(2) of the Pa-  
12 tient Protection and Affordable Care Act (42 U.S.C.  
13 18032)) who wish to make such plan available to  
14 their employees.

15 (4) ELIGIBILITY TO PURCHASE.—Any United  
16 States resident may enroll in the Medicare Transi-  
17 tion buy-in.

18 (c) BENEFITS; ACTUARIAL VALUE.—In carrying out  
19 this section, the Administrator shall ensure that the Medi-  
20 care Transition buy-in provides—

21 (1) coverage for the benefits required to be cov-  
22 ered under title II of this Act; and

23 (2) coverage of benefits that are actuarially  
24 equivalent to 90 percent of the full actuarial value  
25 of the benefits provided under the plan.

1 (d) PROVIDERS AND REIMBURSEMENT RATES.—

2 (1) IN GENERAL.—With respect to the reim-  
3 bursement provided to health care providers for cov-  
4 ered benefits, as described in section 201, provided  
5 under the Medicare Transition buy-in, the Adminis-  
6 trator shall reimburse such providers at rates deter-  
7 mined for equivalent items and services under the  
8 Medicare for All fee-for-service schedule established  
9 in section 612(b) of this Act.

10 (2) PRESCRIPTION DRUGS.—Any payment rate  
11 under this subsection for a prescription drug shall be  
12 at the prices negotiated under section 616 of this  
13 Act.

14 (3) PARTICIPATING PROVIDERS.—

15 (A) IN GENERAL.—A health care provider  
16 that is a participating provider of services or  
17 supplier under the Medicare program under  
18 title XVIII of the Social Security Act (42  
19 U.S.C. 1395 et seq.) or under a State Medicaid  
20 plan under title XIX of such Act (42 U.S.C.  
21 1396 et seq.) on the date of enactment of this  
22 Act shall be a participating provider in the  
23 Medicare Transition buy-in.

24 (B) ADDITIONAL PROVIDERS.—The Ad-  
25 ministrator shall establish a process to allow

1 health care providers not described in subpara-  
2 graph (A) to become participating providers in  
3 the Medicare Transition buy-in. Such process  
4 shall be similar to the process applied to new  
5 providers under the Medicare program.

6 (e) PREMIUMS.—

7 (1) DETERMINATION.—The Administrator shall  
8 determine the premium amount for enrolling in the  
9 Medicare Transition buy-in, which—

10 (A) may vary according to family or indi-  
11 vidual coverage, age, and tobacco status (con-  
12 sistent with clauses (i), (iii), and (iv) of section  
13 2701(a)(1)(A) of the Public Health Service Act  
14 (42 U.S.C. 300gg(a)(1)(A))); and

15 (B) shall take into account the cost-shar-  
16 ing reductions and premium tax credits which  
17 will be available with respect to the plan under  
18 section 1402 of the Patient Protection and Af-  
19 fordable Care Act (42 U.S.C. 18071) and sec-  
20 tion 36B of the Internal Revenue Code of 1986,  
21 as amended by subsection (g).

22 (2) LIMITATION.—Variation in premium rates  
23 of the Medicare Transition buy-in by rating area, as  
24 described in clause (ii) of section 2701(a)(1)(A)(iii)

1 of the Public Health Service Act (42 U.S.C.  
2 300gg(a)(1)(A)) is not permitted.

3 (f) TERMINATION.—This section shall cease to have  
4 force or effect on the effective date described in section  
5 106(a).

6 (g) TAX CREDITS AND COST-SHARING SUBSIDIES.—

7 (1) PREMIUM ASSISTANCE TAX CREDITS.—

8 (A) CREDITS ALLOWED TO MEDICARE  
9 TRANSITION BUY-IN ENROLLEES IN NON-EX-  
10 PANSION STATES.—Paragraph (1) of section  
11 36B(c) of the Internal Revenue Code of 1986  
12 is amended by redesignating subparagraphs (C)  
13 and (D) as subparagraphs (D) and (E), respec-  
14 tively, and by inserting after subparagraph (B)  
15 the following new subparagraph:

16 “(C) SPECIAL RULES FOR MEDICARE  
17 TRANSITION BUY-IN ENROLLEES.—

18 “(i) IN GENERAL.—In the case of a  
19 taxpayer who is covered, or whose spouse  
20 or dependent (as defined in section 152) is  
21 covered, by the Medicare Transition buy-in  
22 established under section 1002(a) of the  
23 Medicare for All Act of 2021 for all  
24 months in the taxable year, subparagraph

1 (A) shall be applied without regard to ‘but  
2 does not exceed 400 percent’.

3 “(ii) ENROLLEES IN MEDICAID NON-  
4 EXPANSION STATES.—In the case of a tax-  
5 payer residing in a State which (as of the  
6 date of the enactment of the Medicare for  
7 All Act of 2021) does not provide for eligi-  
8 bility under clause (i)(VIII) or (ii)(XX) of  
9 section 1902(a)(10)(A) of the Social Secu-  
10 rity Act for medical assistance under title  
11 XIX of such Act (or a waiver of the State  
12 plan approved under section 1115) who is  
13 covered, or whose spouse or dependent (as  
14 defined in section 152) is covered, by the  
15 Medicare Transition buy-in established  
16 under section 1002(a) of the Medicare for  
17 All Act of 2021 for all months in the tax-  
18 able year, subparagraphs (A) and (B) shall  
19 be applied by substituting ‘0 percent’ for  
20 ‘100 percent’ each place it appears.”.

21 (B) PREMIUM ASSISTANCE AMOUNTS FOR  
22 TAXPAYERS ENROLLED IN MEDICARE TRANSI-  
23 TION BUY-IN.—

24 (i) IN GENERAL.—Subparagraph (A)  
25 of section 36B(b)(3) of such Code is

1 amended—(I) by redesignating clause (ii)  
 2 as clause (iii), (II) by striking “clause (ii)”  
 3 in clause (i) and inserting “clauses (ii) and  
 4 (iii)”, and (III) by inserting after clause (i)  
 5 the following new clause:

6 “(ii) SPECIAL RULES FOR TAXPAYERS  
 7 ENROLLED IN MEDICARE TRANSITION BUY-  
 8 IN.—In the case of a taxpayer who is cov-  
 9 ered, or whose spouse or dependent (as de-  
 10 fined in section 152) is covered, by the  
 11 Medicare Transition buy-in established  
 12 under section 1002(a) of the Medicare for  
 13 All Act of 2021 for all months in the tax-  
 14 able year, the applicable percentage for  
 15 any taxable year shall be determined in the  
 16 same manner as under clause (i), except  
 17 that the following table shall apply in lieu  
 18 of the table contained in such clause:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent .....	2.00	2.00
100 percent up to 138 percent .....	2.04	2.04
138 percent up to 150 percent .....	3.06	4.08
150 percent and above .....	4.08	5.00.”.

19 (ii) CONFORMING AMENDMENT.—Sub-  
 20 clause (I) of clause (iii) of section  
 21 36B(b)(3) of such Code, as redesignated

1 by subparagraph (A)(i), is amended by in-  
2 serting “, and determined after the appli-  
3 cation of clause (ii)” after “after applica-  
4 tion of this clause”.

5 (2) COST-SHARING SUBSIDIES.—Subsection (b)  
6 of section 1402 of the Patient Protection and Af-  
7 fordable Care Act (42 U.S.C. 18071(b)) is amend-  
8 ed—

9 (A) by inserting “, or in the Medicare  
10 Transition buy-in established under section  
11 1002(a) of the Medicare for All Act of 2021,”  
12 after “coverage” in paragraph (1);

13 (B) by redesignating paragraphs (1) (as so  
14 amended) and (2) as subparagraphs (A) and  
15 (B), respectively, and by moving such subpara-  
16 graphs 2 ems to the right;

17 (C) by striking “INSURED.—In this sec-  
18 tion” and inserting “INSURED.—  
19 “(1) IN GENERAL.—In this section”;

20 (D) by striking the flush language; and

21 (E) by adding at the end the following new  
22 paragraph:

23 “(2) SPECIAL RULES.—

24 “(A) INDIVIDUALS LAWFULLY PRESENT.—

25 In the case of an individual described in section



1 36B(c)(1)(B) of the Internal Revenue Code of  
2 1986, the individual shall be treated as having  
3 household income equal to 100 percent of the  
4 poverty line for a family of the size involved for  
5 purposes of applying this section.

6 “(B) MEDICARE TRANSITION BUY-IN EN-  
7 ROLLEES IN MEDICAID NON-EXPANSION  
8 STATES.—In the case of an individual residing  
9 in a State which (as of the date of the enact-  
10 ment of the Medicare for All Act of 2021) does  
11 not provide for eligibility under clause (i)(VIII)  
12 or (ii)(XX) of section 1902(a)(10)(A) of the So-  
13 cial Security Act for medical assistance under  
14 title XIX of such Act (or a waiver of the State  
15 plan approved under section 1115) who enrolls  
16 in such Medicare Transition buy-in, the pre-  
17 ceding sentence, paragraph (1)(B), and para-  
18 graphs (1)(A)(i) and (2)(A) of subsection (c)  
19 shall each be applied by substituting ‘0 percent’  
20 for ‘100 percent’ each place it appears.”.

21 (h) CONFORMING AMENDMENTS.—

22 (1) TREATMENT AS A QUALIFIED HEALTH  
23 PLAN.—Section 1301(a)(2) of the Patient Protection  
24 and Affordable Care Act (42 U.S.C. 18021(a)(2)) is  
25 amended—

1 (A) in the paragraph heading, by inserting  
 2 “THE MEDICARE TRANSITION BUY-IN,” before  
 3 “AND”; and

4 (B) by inserting “The Medicare Transition  
 5 buy-in,” before “and a multi-State plan”.

6 (2) LEVEL PLAYING FIELD.—Section 1324(a)  
 7 of the Patient Protection and Affordable Care Act  
 8 (42 U.S.C. 18044(a)) is amended by inserting “the  
 9 Medicare Transition buy-in,” before “or a multi-  
 10 State qualified health plan”.

## 11 **Subtitle B—Transitional Medicare** 12 **Reforms**

### 13 **SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD** 14 **FOR MEDICARE COVERAGE FOR INDIVID-** 15 **UALS WITH DISABILITIES.**

16 (a) IN GENERAL.—Section 226(b) of the Social Secu-  
 17 rity Act (42 U.S.C. 426(b)) is amended—

18 (1) in paragraph (2)(A), by striking “, and has  
 19 for 24 calendar months been entitled to,”;

20 (2) in paragraph (2)(B), by striking “, and has  
 21 been for not less than 24 months,”;

22 (3) in paragraph (2)(C)(ii), by striking “, in-  
 23 cluding the requirement that he has been entitled to  
 24 the specified benefits for 24 months,”;

1           (4) in the first sentence, by striking “for each  
2 month beginning with the later of (I) July 1973 or  
3 (II) the twenty-fifth month of his entitlement or sta-  
4 tus as a qualified railroad retirement beneficiary de-  
5 scribed in paragraph (2), and” and inserting “for  
6 each month for which the individual meets the re-  
7 quirements of paragraph (2), beginning with the  
8 month following the month in which the individual  
9 meets the requirements of such paragraph, and”;  
10 and

11           (5) in the second sentence, by striking “the  
12 ‘twenty-fifth month of his entitlement’” and all that  
13 follows through “paragraph (2)(C) and”.

14 (b) CONFORMING AMENDMENTS.—

15           (1) SECTION 226.—Section 226 of the Social  
16 Security Act (42 U.S.C. 426) is amended by—

17                   (A) striking subsections (e)(1)(B), (f), and

18                   (h); and

19                   (B) redesignating subsections (g) and (i)

20                   as subsections (f) and (g), respectively.

21           (2) MEDICARE DESCRIPTION.—Section 1811(2)  
22 of the Social Security Act (42 U.S.C. 1395c(2)) is  
23 amended by striking “have been entitled for not less  
24 than 24 months” and inserting “are entitled”.

1           (3) **MEDICARE COVERAGE.**—Section 1837(g)(1)  
2 of the Social Security Act (42 U.S.C. 1395p(g)(1))  
3 is amended by striking “25th month of” and insert-  
4 ing “month following the first month of”.

5           (4) **RAILROAD RETIREMENT SYSTEM.**—Section  
6 7(d)(2)(ii) of the Railroad Retirement Act of 1974  
7 (45 U.S.C. 231f(d)(2)(ii)) is amended—

8                   (A) by striking “has been entitled to an  
9 annuity” and inserting “is entitled to an annu-  
10 ity”;

11                   (B) by striking “, for not less than 24  
12 months”; and

13                   (C) by striking “could have been entitled  
14 for 24 calendar months, and”.

15       (c) **EFFECTIVE DATE.**—The amendments made by  
16 this section shall apply to insurance benefits under title  
17 XVIII of the Social Security Act with respect to items and  
18 services furnished in months beginning after December 1  
19 following the date of enactment of this Act, and before  
20 the date that is 2 years after the date of the enactment  
21 of such Act.

22 **SEC. 1012. ENSURING CONTINUITY OF CARE.**

23       (a) **IN GENERAL.**—The Secretary shall ensure that  
24 all persons enrolled or who seeks to enroll in a health plan  
25 during the transition period of the Medicare for All Pro-

1 gram are protected from disruptions in their care during  
2 the transition period, including continuity of care with  
3 such persons current health care provider teams.

4 (b) CONTINUITY OF COVERAGE AND CARE IN GEN-  
5 ERAL.—During the transition period of the Medicare for  
6 All Act, group health plans and health insurance issuers  
7 offering group or individual health insurance coverage  
8 shall not end coverage for an enrollee during the transition  
9 period described in the Act until all ages are eligible to  
10 enroll in the Medicare for All Program except as expressly  
11 agreed upon under the terms of the plan.

12 (c) CONTINUITY OF COVERAGE AND CARE FOR PER-  
13 SONS WITH COMPLEX MEDICAL NEEDS.—

14 (1) The Secretary shall ensure that persons  
15 with disabilities, complex medical needs, or chronic  
16 conditions are protected from disruptions in their  
17 care during the transition period, including con-  
18 tinuity of care with such persons current health care  
19 provider teams.

20 (2) During the transition period of the Medi-  
21 care for All Act group health plans and health insur-  
22 ance issuers offering group or individual health in-  
23 surance coverage shall not—

24 (A) end coverage for an enrollee who has  
25 a disability, complex medical need, or chronic

1 condition during the transition period described  
2 in the Act until all ages are eligible to enroll in  
3 the Medicare for All Program; or

4 (B) impose any exclusion with respect to  
5 such plan or coverage on the basis of a person’s  
6 disability, complex medical need, or chronic con-  
7 dition during the transition period described  
8 under this Act until all ages are eligible to en-  
9 roll in the Medicare for All Program.

10 (d) PUBLIC CONSULTATION DURING TRANSITION.—

11 The Secretary shall consult with communities and advo-  
12 cacy organizations of persons living with disabilities as  
13 well as other patient advocacy organizations to ensure that  
14 the transition buy-in takes into account the continuity of  
15 care for persons with disabilities, complex medical needs,  
16 or chronic conditions.

## 17 **TITLE XI—MISCELLANEOUS**

### 18 **SEC. 1101. DEFINITIONS.**

19 In this Act—

20 (1) the term “global budget” means the pay-  
21 ment negotiated between an institutional provider  
22 and as described in section 611(b);

23 (2) the term “group practice” has the meaning  
24 given such term in section 1877(h)(4) of the Social  
25 Security Act (42 U.S.C. 1395nn(h)(4));

1           (3) the term “individual provider” means a sup-  
2 plier (as defined in section 1861(d) of such Act (42  
3 U.S.C. 1395x(d)));

4           (4) the term “institutional provider” means—

5                 (A) providers of services described in sec-  
6 tion 1861(u) of such Act (42 U.S.C. 1395x(u));

7                 (B) hospitals as defined in section 1861(e)  
8 of the Social Security Act (42 U.S.C.  
9 1395x(e)), and any outpatient settings or clinics  
10 operating within a hospital license or any set-  
11 ting or clinic that provides outpatient hospital  
12 services;

13                 (C) psychiatric hospitals (as defined in sec-  
14 tion 1861(e) of the Social Security Act (42  
15 U.S.C. 1395x(f)));

16                 (D) rehabilitation hospitals (as defined by  
17 the Secretary of Health and Human Services  
18 under section 1886(d)(1)(B)(ii) of the Social  
19 Security Act (42 U.S.C. 1395ww(d)(1)(B)(ii)));

20                 (E) long-term care hospitals as defined in  
21 section 1861 of the Social Security Act (42  
22 U.S.C. 1395x(ccc)); and

23                 (F) independent dialysis facilities and inde-  
24 pendent end-stage renal disease facilities as de-  
25 scribed in 42 CFR 413.174(b);

1           (5) the term “medically necessary or appro-  
2           priate” means the health care items and services or  
3           supplies that are needed or appropriate to prevent,  
4           diagnose, or treat an illness, injury, condition, dis-  
5           ease, or its symptoms for an individual and are de-  
6           termined to be necessary or appropriate for such in-  
7           dividual by the physician or other health care profes-  
8           sional treating such individual, after such profes-  
9           sional performs an assessment of such individual’s  
10          condition, in a manner that meets—

11                   (A) the scope of practice, licensing, and  
12                   other law of the State in which the individual  
13                   receiving such items and services is located; and

14                   (B) appropriate standards established by  
15                   the Secretary for purposes of carrying out this  
16                   Act;

17          (6) the term “provider” means an institutional  
18          provider or a supplier (as defined in section 1861(d)  
19          of such Act (42 U.S.C. 1395x(d)) if the reference to  
20          “this title” were a reference to the Medicare for All  
21          Program);

22          (7) the term “Secretary” means the Secretary  
23          of Health and Human Services;



1           (8) the term “State” means a State, the Dis-  
2           trict of Columbia, or a territory of the United  
3           States;

4           (9) the term “TRICARE Overseas Program”  
5           means the element of the TRICARE program ad-  
6           ministered by International SOS (or such successor  
7           administrator) under which care and health benefits  
8           are furnished to TRICARE beneficiaries located in  
9           a TRICARE overseas region;

10          (10) the term “TRICARE program” has the  
11          meaning given such term in section 1072 of title 10,  
12          United States Code;

13          (11) the term “uniformed services” has the  
14          meaning given such term in section 101 of title 10,  
15          United States Code; and

16          (12) the term “United States” shall include the  
17          States, the District of Columbia, and the territories  
18          of the United States.

19 **SEC. 1102. RULES OF CONSTRUCTION.**

20          (a) IN GENERAL.—A State or local government may  
21          set additional standards or apply other State or local laws  
22          with respect to eligibility, benefits, and minimum provider  
23          standards, only if such State or local standards—

24                 (1) provide equal or greater eligibility than is  
25                 available under this Act;

1           (2) provide equal or greater in-person access to  
2           benefits under this Act;

3           (3) do not reduce access to benefits under this  
4           Act;

5           (4) allow for the effective exercise of the profes-  
6           sional judgment of physicians or other health care  
7           professionals; and

8           (5) are otherwise consistent with this Act.

9           (b) RELATION TO STATE LICENSING LAW.—Nothing  
10          in this Act shall be construed to preempt State licensing,  
11          practice, or educational laws or regulations with respect  
12          to health care professionals and health care providers, for  
13          such professionals and providers who practice in that  
14          State.

15          (c) APPLICATION TO STATE AND FEDERAL LAW ON  
16          WORKPLACE RIGHTS.—Nothing in this Act shall be con-  
17          strued to diminish or alter the rights, privileges, remedies,  
18          or obligations of any employee or employer under any Fed-  
19          eral or State law or regulation or under any collective bar-  
20          gaining agreement.

21          (d) RESTRICTIONS ON PROVIDERS.—With respect to  
22          any individuals or entities certified to provide items and  
23          services covered under section 201(a)(7), a State may not  
24          prohibit an individual or entity from participating in the

1 program under this Act for reasons other than the ability  
2 of the individual or entity to provide such services.

3 **SEC. 1103. NO USE OF RESOURCES FOR LAW ENFORCE-**  
4 **MENT OF CERTAIN REGISTRATION REQUIRE-**  
5 **MENTS.**

6 Notwithstanding any provision of Federal or State  
7 law, no Federal or State law enforcement official or em-  
8 ployee shall use any funds, facilities, property, equipment,  
9 or personnel made available pursuant to this Act (or any  
10 amendment made thereby) to investigate, enforce, or as-  
11 sist in the investigation or enforcement of any criminal,  
12 civil, or administrative violation or warrant for a violation  
13 of any requirement that individuals register with the Fed-  
14 eral Government based on religion, national origin, eth-  
15 nicity, immigration status, or other protected category.

○