# The Patient Protection and Affordable Care Act: A Section-by-Section Summary

**2010**

# Contents

# Preface

On March 21, 2010, the United States Congress passed the Patient Protection and Affordable Care Act, as part of Congress' comprehensive health reform legislation. This document is a section-by-section summary of the Act as signed into law March 23, 2010.

The reader should note that the summary maintains the same structure of the actual legislation. All references to "the Secretary" refer to the Secretary of the Department of Health and Human Services unless otherwise stated.

Additionally, this legislation went through several revisions before being passed by Congress. As a result of the legislative process there are some inconsistencies in the text of the law. Further changes were made after the Affordable Care Act was signed into law with the passage of the Health Care and Education Reconciliation Act. In order to clarify what modifications were made, please see the key below.

Key to Text
*Italicized text* indicates modifications were made in a later section of the Affordable Care Act.

*Yellow italicized text* indicates the section of the Affordable Care Act where changes were made.

*Blue italicized text* indicates changes made by the Health Care and Education Reconciliation Act.

# Title I - Quality, Affordable Health Care for All Americans

## Subtitle A - Immediate Improvements in Health Care Coverage for All Americans

### Section 1001. Amendments to the Public Health Service Act

A health insurance issuer offering group or individual health insurance coverage will be subject to the following conditions:

- Cannot establish lifetime limits on the dollar value of essential benefits;
- Cannot establish unreasonable annual limits on the dollar value of essential benefits;
- Can place limits on specific non-essential coverage benefits to the extent that Federal or State law permits;
- Cannot rescind a plan or coverage unless the individual is fraudulent or intentionally misrepresents material facts;
- Cannot impose any cost-sharing requirements for preventive services recommended with a grade of A or B by the Preventive Services Task Force or in guidelines from the Health Resources and Services Administration (HRSA);
- Must cover ~~unmarried~~ adult children until the child turns 26 if the plan already covers dependent children;
- Must provide enrollees a summary of benefits, cost-sharing, renewal provisions, limitations, and examples of common benefits scenarios under the applicable plan or coverage, with summary following standards developed by the Secretary within 12 months of enactment;
- Cannot establish eligibility rules that have the effect of discriminating in favor of higher wage employees;

Within 2 years of the date of enactment of this Act, the Secretary, in consultation with health care quality experts and stakeholders, will develop annual reporting requirements for group health plans and health insurance issuers offering group or individual health insurance coverage, for plans or benefits that:

- Improve health outcomes through activities such as quality reporting, effective case management, care coordination, and medication and care compliance initiatives;
- Implement activities to prevent hospital readmissions;
- Implement activities to improve patient safety and reduce medical errors; and
- Implement wellness and health promotion activities.

A health insurance issuer offering group or individual health insurance coverage will be subject to the following conditions:

- Must submit an annual report to the Secretary documenting the percentage of total premium revenue that is spent on clinical services, activities that improve health care quality, and all other non-claims costs;
- *Must provide rebates to enrollees for the amount by which premium revenue expended by the issuer for non-claims costs exceeds 20 percent in the group market and 25 percent in the individual market;* and
- Must implement an appeals process for appeals of coverage determinations and claims.

Hospitals must annually make public a list of standard charges for items and services provided, including for diagnosis-related groups established under the Social Security Act.

*(This subsection is revised in section 10101)*
*(This subsection is further modified in section 2301 of the Reconciliation Act)*

**Section 1002. Health Insurance Consumer Information**

The Secretary will award grants to States to establish, expand, or provide support for offices of health insurance customer assistance or health insurance ombudsman programs. To receive a grant, a State must designate an independent office of health insurance consumer assistance or an ombudsman that receives and responds to inquiries and complaints about health insurance coverage. This office will assist with:

- Filing complaints and appeals;
- Collecting, tracking, and quantifying problems and inquiries;
- Educate consumers on their rights and responsibilities;
- Enrolling consumers in a group health plan or health insurance coverage; and
- Resolving problems with obtaining premium tax credits.

This office must collect and report data to the Secretary on the inquiries and types of problems reported.

There will be $30 million available for the first year of this program and such sums as may be necessary for subsequent years.

**Section 1003. Ensuring That Consumers Get Value for Their Dollars**

The Secretary and the States will establish a process for an annual review for unreasonable increases of premiums for health insurance coverage. Insurers must make premium increases and their justification public prior to implementation.

States will provide the Secretary with information regarding trends in premium increases and make recommendations to the State Exchange about whether an insurer should be excluded because of unjustified premium increases.

The Secretary will award grants to States to assist in reviewing and approving premium increases.

There will be a total of $250 million available for grants under this section.

**Section 1004. Effective Dates**

The programs in the preceding subtitle will be effective for plan years beginning 6 months after the Act is enacted.

## Subtitle B - Immediate Actions to Preserve and Expand Coverage

**Section 1101. Immediate Access to Insurance for Uninsured Individuals with a Preexisting Condition**

Within 90 days of enactment, the Secretary will establish a temporary high-risk health insurance pool program to provide health insurance coverage for individuals who have a pre-existing condition and have been uninsured for at least 6 months. This program may be carried out by the Secretary directly, a State, or private nonprofit entity. In order for a State to be eligible, the State must not reduce funding for State

high-risk pools in the year prior to entering into a contract with the Secretary. Coverage for eligible individuals under a high-risk pool in a State will terminate January 1, 2014.

The high-risk pool must provide health insurance coverage that:

- Is available to all eligible individuals;
- Does not impose any exclusions for preexisting conditions;
- Covers at least 65 percent of the cost of benefits;
- Has an out-of-pocket limit not greater than the amount described by section 223 of the Internal Revenue Code;
- Abides by the premium rate requirements of section 2701 of the Public Service Act; and
- Has premiums rates that are no more than 4 times greater than the lowest rate when adjusted for age.

The Secretary will establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in coverage based on the individual's health condition. If the Secretary finds that an individual was encouraged to disenroll from a health benefits coverage plan, then the issuer or employment-based health plan must reimburse the high-risk program for that individual. The Secretary will establish an appeals process for individuals to appeal a determination and procedures to protect against waste, fraud, and abuse.

This Act makes available $5 billion for the Secretary to pay claims of the high-risk pool that are in excess of the amount of premiums collected from individuals enrolled in the pool. If funds are limited, then the Secretary may refuse applications for participating in the program. This Section supersedes any State law or regulation with respect to qualified high-risk pools.

**Section 1102. Reinsurance for Early Retirees**

The Secretary will establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees, within 90 days of enactment and ending on January 1, 2014. Early retirees are individuals who are 55 or older and are not eligible for coverage under Medicare, and are neither active employees nor contributing to the employment-based plan of any employer.

Participating employment-based plans must:

- Implement programs and procedures to reduce costs with respect to participants with chronic and high cost conditions;
- Provide documentation of the actual cost of medical claims; and
- Be certified by the Secretary.

Participating employment-based plans may submit claims for reimbursement to the Secretary. The Secretary will reimburse the plan for 80 percent of that portion of the costs of claims exceeding $15,000. The claims must be between $15,000 and $90,000, and payments must be used to lower plan or premium costs.

These payments will not be included in determining the plan operator's gross income. An appeals process and procedures to protect against fraud, waste, and abuse will be established. The Secretary shall conduct annual audits of claims data. The act makes available $5 billion of to carry out this program. The Secretary may stop taking applications in the case of insufficient funds.

**Section 1103. Immediate Information That Allows Consumers to Identify Affordable Coverage Options**

By July 2010, the Secretary and States will establish a mechanism for residents to identify affordable health insurance options in their home state. This will include an internet website with health insurance coverage offered by health insurance issuers, Medicaid, Social Security, a State high-risk pool, and coverage under a high-risk pool under section 1101.

The Secretary will develop a standardized form to present information about coverage options within 60 days, which will include: eligibility, availability, the percentage of total premium revenue expended on nonclinical costs, premium rates, and cost-sharing options. The Secretary may carry out this section through contracts with other entities.

**Section 1104. Administrative Simplification**

The Secretary will adopt operating rules for electronic transactions to create uniformity in the implementation of electronic standards. Operating rules will:

- Be consensus-based;
- Reflect the necessary business rules affecting health plans and health care providers;
- Build on the transaction standards issued under the Health Insurance Portability and Accountability Act of 1996.

The Secretary will consider recommendations for operating rules developed by a qualified nonprofit entity. The National Committee on Vital and Health Statistics will review the operating rules, determine if they are consistent with existing standards, and submit recommendations to the Secretary.

Operating rules for eligibility for a health plan and health claim status transactions will be adopted by July 1, 2011, and must be effective by January 1, 2013; for electronic fund transfers and health care payment will be adopted by July 1, 2012, and must be effective by January 1, 2014; and for health claims, enrollment and disenrollment of a health plan, and premium payments will be adopted by July 1, 2014, and must be effective by January 1, 2016.

A health plan will file a statement and documentation with the Secretary certifying that data and information systems for such plan are in compliance with any applicable standards. The Secretary may designate independent, outside entities to certify that a health plan has complied with these requirements. The Secretary will conduct periodic audits to ensure that health plans are in compliance.

By April 1, 2014, the Secretary will annually assess a penalty fee against a health plan that has failed to meet requirements with respect to certification and documentation. The fee will be $1 per covered person until certification is complete. The penalty fee will be doubled for a health plan that knowingly provides inaccurate information about certification or documentation. The amount of the penalty fee will be increased annually based on the annual percentage increase in total health care expenditures. Fees will be collected by the Secretary of the Treasury.

**Section 1105. Effective Date**

The subtitle above will take effect on the date of enactment of this Act.

## Subtitle C - Quality Health Insurance Coverage for All Americans

### Part I - Health Insurance Market Reforms

### Section 1201. Amendment to the Public Health Services Act

Group health plans and health insurance issuers will be subject to the following conditions:

- Cannot impose any preexisting condition exclusions;
- Can only vary the premium rate in the individual or small group market based on family size, rating area location, age by no more than 3 to 1, and tobacco use by no more than 1.5 to 1;
- Must accept every employer and individual in the state that applies for coverage. There may be annual open enrollment periods and special enrollment periods for qualifying events;
- Must renew coverage at the option of the plan sponsor or the individual;
- Cannot establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor determined by the Secretary;
- May provide awards of up to 30 percent of premiums to employees who participate in wellness programs such as fitness center memberships, diagnostic testing, preventive care, quitting smoking, and attending health education seminars.

The Secretary will establish a 10-State wellness program demonstration project by July 1, 2014. If the Secretary determines the demonstration project is effective, the Secretary may expand demonstration projects to additional states after July 1, 2017. Within 3 years, the Secretary shall submit a report to Congress concerning the effectiveness of wellness programs, their impact on access to care and affordability of coverage, and the premium-based and cost-sharing incentives on participant behavior.

Group health plans and health insurance issuers will be subject to the following conditions:

- Cannot discriminate against any health care provider acting under applicable State law;
- Must ensure that their coverage for the individual and small group market includes the essential health benefits package and cost-sharing limitations required in Section 1302; and
- Cannot apply any waiting period longer than 90 days.

### Part II - Other Provisions

### Section 1251. Preservation of Right to Maintain Existing Coverage

No individual is required to terminate his or her coverage under a group health plan or health insurance coverage in which that individual was already enrolled before the enactment of this Act.

New employees, their family members, and family members of currently enrolled employees may still enroll under a group health plan that provides coverage on the date of enactment of this Act.

Collective bargaining agreements made before the enactment of this act will not be subject to this Act until such an agreement terminates.

### Section 1252. Rating Reforms Must Apply Uniformly to All Health Insurance Issuers and Group Health Plans

Any standard or requirement adopted by a State must be applied uniformly to all health plans in each insurance market.

**Section 1253. Effective Dates**

This subtitle shall become effective for plan years beginning on or after January 1, 2014.

## Subtitle D - Available Coverage Choices for All Americans

**Part I - Establishment of Qualified Health Plans**

**Section 1301. Qualified Health Plan Defined**

Qualified health plans are plans that meet the criteria for certification described in section 1311 and are issued or recognized by an Exchange. The plan must provide the essential health benefits package described in section 1302 and be offered by a health insurance issuer that is licensed, in good standing, and offers at least one plan at the silver level and one plan at the gold level. The issuer must also charge the same premium rate regardless of whether the plan is offered through an Exchange, directly, or through an agent. The health insurance issuer must comply with regulations developed by the Secretary under section 1311.

A qualified health plan will include a qualified health plan offered through the CO-OP program under section 1322 *or* ~~*a community health insurance option under section 1323*~~.

*(This subsection is revised in section 10104)*

**Section 1302. Essential Health Benefits Requirements**

The term essential health benefits package means coverage that provides for the essential health benefits defined by the Secretary. These benefits include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

The scope of the essential health benefits shall be equal to the scope of benefits provided under a typical employer plan. The Secretary will provide an opportunity for public comment in defining and revising essential health benefits.

A health plan may provide benefits in excess of the essential health benefits.

Health plans must limit cost-sharing. The deductible for a plan in the small group market plan may not exceed $2,000 for a single individual plan and $4,000 for any other plan. Cost-sharing includes deductibles, coinsurance, copayments or similar charges and any other expenditure for the insured individual which is a qualified medical expense. Cost-sharing does not include premiums, balance billing accounts for non-network providers, or spending on non-covered services.

Health plan levels of coverage are defined as:

- Bronze- provides benefits equal to 60 percent of the full monetary value of benefits provided;
- Silver- provides benefits equal to 70 percent of the full monetary value of benefits provided;
- Gold- provides benefits equal to 80 percent of the full monetary value of benefits provided; or
- Platinum- provides benefits equal to 90 percent of the full monetary value of benefits provided.

Catastrophic plans must cover essential health benefits and at least 3 primary care visits. Such plans must require cost-sharing. To be eligible for a catastrophic plan, an individual must be under the age of 30 and be unable to afford coverage.

Any issuer offering a qualified health plan through the Exchange must also offer that plan at that level for individuals under age 21.

**Section 1303. Special Rules**

Coverage of abortion services is not required to be part of a qualified health plan. The issuer of a qualified health plan will determine whether or not the plan provides coverage of the following services based on the law as in effect 6 months prior to the start of the plan year involved:

- Abortions services for which public funding is prohibited; or
- Abortion services for which public funding is allowed.

No tax credit or cost-sharing credits may be used to pay for abortion for which public funding is prohibited. *Issuers of plans that offer coverage for abortions for which public funding is prohibited must segregate from any premium and cost-sharing credits an amount of each enrollee's private premium dollars that is sufficient to cover the provision of those services. The Secretary will estimate the monthly per enrollee cost of including coverage of abortions for which federal funding is not allowed.*

*Individual health care provider or health care facility may not be discriminated against due to a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.*

Nothing in this Act affects State or Federal laws regarding abortion.

*(This section is modified in section 10104)*

**Section 1304. Related Definitions**

Group Market: the health insurance market in which individuals obtain coverage through a group health plan maintained by an employer.

Individual Market: the market where health insurance coverage is offered to individuals with no connection to a group health plan.

Large and small group markets: the health insurance market under which an individual gets coverage through a group health plan maintained by a large employer (101 or more employees) or a small employer (1-100 employees).

For plan years beginning before January 1, 2016, a State may elect to identify small employers as those with 1 to 50 employees and large employers as those with 51 or more employees.

Growing small employers may continue to be treated as small employers if they offer enrollment in a qualified plan to employees and cease to be a small employer because of an increase in their number of employees.

**Part II - Consumer Choices and Insurance Competition Through health Benefit Exchanges**

**Section 1311. Affordable Choices of Health Benefit Plans**

The Secretary will make grants to States for the planning and establishment of an American Health Benefit Exchange. The grants may be renewed if the state is making progress toward establishing the Exchange, implementing reforms in subtitles A and C, and meeting benchmarks established by the Secretary. All grants must be awarded by January 1, 2015.

Each State must establish an American Health Benefit Exchange (Exchange) by January 1, 2014. The Exchange must facilitate the purchase of qualified health plans and provide for the establishment of a Small Business Health Options Program (SHOP Exchange) that assists small employers with enrolling their employees in qualified health plans in the small group market. A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services if there are adequate resources to do so.

The Secretary will establish criteria for the certification of health plans as qualified health plans. To be certified plans must:

- Meet marking requirements;
- Ensure choice of providers and provide information about in-network and out-of-network providers;
- Include within insurance plan networks community providers who serve low-income and medically-underserved individuals;
- Be accredited or receive accreditation within a specified period;
- Implement a quality improvement strategy;
- Utilize a uniform enrollment form;
- Utilize the standard format for presenting health benefit plan options; and
- Provide information on any quality measures for health plan performance.

The Secretary shall develop a rating system on the basis of quality and price for qualified health plans offered through an Exchange. The Exchange will include this information to individuals and employers through an Internet portal. The Secretary shall develop an enrollee satisfaction survey system to evaluate satisfaction of plans offered through an Exchange, and this information will be available through the Internet portal. The Secretary will operate, maintain, and update an Internet portal and will assist States in developing and maintaining their own Internet portal. A model template for an internet portal will be available for Exchanges.

The Secretary will require that an Exchange have an initial enrollment period, annual open enrollment periods, and special enrollment periods. Exchanges will be a governmental agency or a nonprofit entity established by a State. All plans offered by an Exchange must be qualified health plans. A State may require additional benefits to those required for a health plan to be qualified, and the State is responsible for the cost. An Exchange will, at a minimum:

- Establish procedures for certification, recertification, and decertification of health plans as qualified health plans;
- Provide a toll-free hotline for assistance;
- Maintain a website with standardized, comparative information on plans;

- Assign a rating to each plan offered;
- Utilize a standardized format for presenting health plan options;
- Inform individuals of eligibility requirements for Medicaid, Children's Health Insurance Program (CHIP), or other state or public programs and enroll eligible individuals in such programs;
- Establish a calculator to determine the actual cost of coverage after tax credits;
- Grant certification attesting to an individual's inability to obtain coverage because there is no affordable option or the individual meets the requirements for other exemptions; and
- Establish a Navigator program.

Beginning in 2015, each Exchange must be self-sustaining. Exchanges will be able to charge assessments or user fees and will consult with stakeholders relevant to carrying out their activities. An Exchange will publish their costs and monies lost to waste, fraud, and abuse.

*An Exchange may certify a health plan as qualified if the plan meets the requirements of the Secretary and the Exchange determines that the plan is in the interests of qualified individuals and employers.* The Exchange will require health plans seeking certification to submit justification for any premium increase prior to its implementation.

An Exchange may operate in more than one State, if approved. A State may also establish multiple Exchanges in the State, if one Exchange serves a distinct area or large area. *An Exchange will periodically review the activities of a qualified health plan that implements one of the following strategies:*

- *Improve health outcomes through the implementation of quality reporting, case management, chronic disease management, or medication and care compliance initiatives;*
- *Implement activities to prevent hospital readmissions;*
- *Implement activities to improve patient safety and reduce medical errors; and*
- *Implement wellness and health promotion activities.*

Beginning on January 1, 2015, a qualified health plan may contract with a hospital with more than 50 beds if it utilizes a patient safety evaluation system and implements a mechanism to ensure each patient receives a comprehensive program for hospital discharge. The Secretary may establish reasonable exceptions to this requirement.

An Exchange will award grants to eligible entities to serve as navigators that:

- Conduct public education activities;
- Distribute fair and impartial information on enrollment in qualified health plans and availability of tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals to appropriate State agencies for enrollees with grievances, complaints or questions about their health plan or coverage; and
- Provide information in a culturally and linguistically appropriate manner.

Mental health parity will apply to qualified health plans in the same manner and to the same extent as it applies to health insurance issuers and group health plans.

*(This section is amended in section 10104)*

**Section 1312. Consumer Choice**

Any qualified individual may enroll in any qualified health plan available to such a person. Employers may provide support for coverage at any level, and employees may choose to enroll in a qualified plan that offers coverage at that level.

A health insurance issuer will consider all enrollees in plans offered in the individual market by that issuer to be members of a single risk pool, regardless if the plans are through the Exchange. A health insurance issuer will consider all enrollees in plans offered in the small group market by that issuer to be members of a single risk pool, regardless if the plans are through the Exchange. This excludes grandfathered health plans. A State may require that individual and small group markets are merged.

Health insurance issuers can offer health plans outside of the Exchange. Qualified individuals and qualified employers may enroll in or select health plans offered outside of an Exchange. Individuals will not be compelled to enroll or not to enroll in a qualified health plan or participate in an Exchange. Members of Congress and congressional staff must participate in a health plan created by this Act or offered through an Exchange established by this Act.

States may allow agents or brokers to enroll individuals in qualified health plans and assist individuals in applying for tax credits and cost-sharing reductions for plans sold through an Exchange.

A qualified individual is defined as an individual looking to enroll in a qualified health plan in the Exchange, who resides in the State that established the Exchange. Incarcerated individuals are not qualified individuals. A qualified employer is a small employer that elects to make all full-time employees eligible for a qualified health plan in the Exchange.

Beginning in 2017, each State may allow issuers to offer qualified health plans in the large group market through an Exchange. If a State allows this, a qualified employer will include a large employer that elects to make all full-time employees eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

If an individual is not a citizen or lawfully residing in the United States, the individual will not be treated as a qualified individual and may not be covered under a plan offered through an Exchange.

**Section 1313. Financial Integrity**

An Exchange will account for expenditures through the following:

- Keep an accurate account of all activities, receipts, and expenditures and will annually submit a report to the Secretary;
- May be subject to investigation by the Secretary;
- Be subject to annual audits;
- Lose payments for engaging in serious misconduct;
- Implement measures or procedures that reduce fraud and abuse;
- Have payments made by, through, or in connection with the Exchange be subject to the False Claims Act; and
- *Be studied by the Comptroller General within 5 years of the operational date of the Exchange*.

*(This section is amended in section 10104)*

**Part III - State Flexibility Relating to Exchanges**

**Section 1321. State Flexibility in Operation and Enforcement of Exchanges and Related Requirements**

The Secretary will issue regulations setting standards for meeting the requirements under this title and the amendments made by this title as soon as practicable after the enactment date of this Act. These regulations will include:

- The establishment and operation of Exchanges, including SHOP Exchanges;
- The offering of qualified health plans though such Exchanges; and
- The establishment of the reinsurance and risk adjustment programs.

Each State that elects to apply for the requirements will, by January 1, 2014, have in effect either Federal standards previously established, or a State law or regulation that meets the implantation standard, determined by the Secretary, within the State.

If there is a failure to establish an Exchange or implement requirements by January 1, 2013, the Secretary will establish and operate such an Exchange within the State and will take actions necessary to implement other requirements.

Nothing in this title will be construed to impede any State law that does not prevent the application of the provisions of this title.

In the case that a State operates an Exchange before January 1, 2010 and has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, the Secretary will presume that such Exchange meets the standards.

**Section 1322. Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers**

The Consumer Operated and Oriented Plan (CO-OP) programs will be established to foster the creation of qualified nonprofit health insurance issuers. These issuers will offer qualified health plans in the individual and small group markets.

The Secretary will provide loans for start-up costs, and grants for assistance meeting solvency requirements. To award loans and grants the Secretary will take into account the following:

- Recommendations of an advisory board;
- If qualified health plans are offered on a statewide basis, use integrated care models, and have private support; and
- Ensure there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State.

If no health insurance issuer applies to be a qualified nonprofit health insurance issuer, the Secretary may award grants to encourage the establishment of a qualified nonprofit health insurance issuer in the State. Loan or grant recipients must be treated as a qualified nonprofit health insurance issuer. Loans and grants may not be used for propaganda or marketing. Penalties will incur if requirements are not met. The Secretary will award loans and grants under the CO-Op program by July 1, 2013.

A qualified nonprofit health insurance is an organization:

- Organized under State law as a nonprofit;

- Whose activities mostly consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed;
- That was not a health insurance issuer on July 16, 2009;
- That is not sponsored by a State or local government or any political subdivision;
- Where the governance of the organization is subject to a majority vote of its members;
- Where its governing documents incorporate ethics and conflict of interest standards; and
- Operated with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

A qualified nonprofit insurance issuer must use profits to lower premiums, to improve benefits, or for other programs to improve the quality of health care for members.

To be considered qualified, an organization must meet all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers plans. An organization cannot offer a qualified health plan in a State until the State has enacted market reforms required by part A of title XXVII of the Public Health Service Act, as amended by this Act.

Qualified nonprofit health insurance issuer participating in the CO-OP program may establish a private purchasing council to enter into collective purchasing arrangements to purchase items and services that increase efficiencies. The council may not set rates for health care facilities or providers.

There are $6 billion appropriated to carry out this section.

A qualified nonprofit health insurance issuer that receives a loan or grant under the CO-OP program is eligible to be tax exempt. The Comptroller General of the General Accountability Office will conduct an ongoing study on competition and market concentration in the health insurance market and report results every 2 years.

**Section 1323. Community Health Insurance Option**

*(This section is stricken in section 10104)*

**Section 1324. Level Playing Field**

Any health insurance coverage offered by a private health insurance issuer is subject to the same Federal and State laws that apply to qualified health plans offered under the Consumer-Operated and Oriented Plan program (section 1322), ~~*the community health insurance option (section 1323) and the nationwide qualified health plan (section 1333)*~~.

*(This section is modified in section 10104)*

**Part IV - State Flexibility to Establish Alternative Programs**

**Section 1331. State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid**

The Secretary will establish a standard health plan under which a State may enter into a contract with 1 or more standard health plans that provide at least the essential health benefits described in section 1302(b) to eligible individuals instead of offering coverage through an Exchange.

States may only establish standard health programs if the Secretary certifies that the amount of the monthly premium and cost-sharing requirements do not exceed the amount the eligible individual would have been required to pay in applicable plans in an Exchange.

A State basic health program will establish a competitive process for entering into contracts with standard health plans, including negotiation of premiums, cost-sharing, and any additional benefits. As part of this process, a State must include at least one of the following:

- Innovative features, including care coordination and management, incentives for using preventive services or increasing patient involvement;
- Consideration of health and resource differences;
- Contracts with managed care systems;
- Performance measures;
- Multiple plans or regional compacts; and
- Coordination with a State Medicaid program, a State child health plan, and other State-administered programs.

Funds will be given to States electing to offer a standard health plan and such States will establish a trust fund that will be used to reduce premiums and cost-sharing and to provide benefits. The Secretary will determine the amount of payment, *which will be 85 percent* of the premium tax credit and cost-sharing reduction that would have been provided to individuals in standard health plans in the State through an Exchange. The Chief Actuary for the Centers for Medicare and Medicaid (CMS) will certify the methodology used to allocate funds.

To be eligible for a standard health plan an individual will:

- Be a resident of the State who is not eligible for the State's Medicaid program;
- Have an income that is between 133 percent and 200 percent of the poverty line;
- Not be eligible for minimum essential coverage or cannot afford employer-sponsored coverage;
- Be under age 65; and
- Not be eligible to use an Exchange.

The Secretary will conduct an annual review of each State program to ensure compliance.

*(This section is modified in section 10104)*

**Section 1332. Waiver for State Innovation**

A State may apply to the Secretary for the waiver of all or any requirements for qualified health plans, Exchanges, cost-sharing reductions, and tax credits within the State for plan years beginning after January 1, 2017.

The application will include:

- A comprehensive description of the State legislation and program to meet waiver requirements;
- A 10-year budget plan that is budget neutral to the Federal Government;
- An assurance that coverage is at least as comprehensive as coverage defined in section 1302(b) and offered through Exchanges; and
- An assurance that the State plan will provide coverage to at least a comparable number of its residents as the provisions of this title would provide.

A State must enact a law to be eligible for a waiver. A State may terminate the waiver by repealing a law. Waivers may not last longer than 5 years unless the State requests a continuation of such a waiver.

**Section 1333. Provisions Relating to Offering of Plans in More than One State**

By July 1, 2013, the Secretary will issue regulations for the creation of interstate health care choice compacts under which 2 or more States may enter into an agreement that allows for the same qualified health plans to be offered in these States.

A State must enact a law to enter into such agreements. The Secretary will approve interstate health care choice compacts if the compact:

- Provides coverage at least as comprehensive as coverage defined in section 1302(b) and offered through Exchanges;
- Provides coverage and cost-sharing protections that are at least as affordable as this title would provide;
- Provides coverage to at least a comparable number of residents as this title would;
- Does not increase the Federal deficit; and
- Does not weaken enforcement of laws and regulations in any State included in such compact.

Health care choice compacts may not take effect until January 1, 2016.

*(A subsection is stricken in section 10104)*

**Part V - Reinsurance and Risk Adjustment**

**Section 1341. Transitional Reinsurance Program for Individuals and Small Group Markets in Each State**

By January 1, 2014, each State will establish 1 or more applicable reinsurance entities to carry out a reinsurance program. Health insurance issuers and third party administrators will be required to make payments to an applicable reinsurance agency. These payments will be used to help cover high-risk individuals.

The Secretary will develop a method for determining health insurance issuer and group health plan contributions to the reinsurance program. Insurers will be required to contribute $25 billion between 2014 and 2016.

An applicable reinsurance entity is a nonprofit organization whose purpose is to help stabilize premiums for coverage in the individual and small group markets. A state may have more than 1 applicable reinsurance entity and 2 or more States may enter into agreements to provide for an applicable reinsurance entity. The state may eliminate or modify any State high-risk pool to carry out the reinsurance program.

**Section 1342. Establishment of Risk Corridors for Plans in Individual and Small Group Markets**

The Secretary will establish and administer a risk corridor program between 2014 and 2016, which will make payment adjustments depending on a qualified health plan's expenditures on allowable costs. If a plan's total allowable costs are more than 103 percent of the targeted amount, then the Secretary will make payments to the plan. If the plan's total allowable costs are less than 97 percent of the target amount, then the plan will make payments to the Secretary. Allowable costs are an amount equal to the total costs of a plan, less administrative costs, for providing benefits. The target amount is an amount equal to the total premiums minus administrative costs of the plan.

### Section 1343. Risk Adjustment

Each State will assess a charge on health plans and health insurance issuers where enrollees have lower than average actuarial risk in the State, excluding self-insured group health plans. Each state will provide payments to plans and issuers where actuarial risk is higher than the average in the State. This risk adjustment applies to plans in the individual and small group markets, and does not to a grandfathered health plan or issuer of a grandfathered plan.

## Subtitle E - Affordable Coverage Choices for All Americans

### Part I - Premium Tax Credits and Cost-Sharing Reductions

### Subpart A - Premium Tax Credits and Cost-Sharing Reductions

### Section 1401. Refundable Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan

If an individual is covered under a qualified health plan, then that individual will receive a premium assistance credit, which will be the sum of the premium assistance amounts for all coverage months of the year. The premium assistance amounts are calculated as the lesser of the following two:

- The monthly premiums of an individual's qualified health plans; or
- The excess, if any, of:
    - Monthly premium ÷ [(Applicable percentage × Annual household income) ÷ 2]

The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer lives. An applicable taxpayer is a taxpayer with household over between 100 and 400 percent of the poverty line. All persons to whom this section applies must be lawfully present in the United States. The amount of the credit allowed under this section for any taxable year will be reduced by the amount of any advance payment of such credit under section 1412.

The Secretary will prescribe regulations as needed for the coordination of the credit and advance payment of the credit in section 1412 and tax filing status considerations. The Comptroller General will conduct a study on the affordability of health insurance coverage within 5 years.

The amendments of this section will apply to taxable years ending after 2013.

*(This section is modified in section 1001 of the Reconciliation Act)*

### Section 1402. Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans

For those enrolled in qualified health plans through an Exchange with income between 100 and 400 percent of the poverty line, there will be a reduction in cost-sharing. In general, out-of-pocket limits would be reduced by:

- 2/3 for those between 100-200 percent of the poverty line;
- 1/2 for those between 200-300 percent of the poverty line; and
- 1/3 for those between 300-400 percent of the poverty line.

The Secretary would ensure the plan's share of the total allowed costs of benefits provided would not exceed:

- *94 percent* for those between 100-150 percent of the poverty line; and
- *87 percent* for those between 150-200 percent of the poverty line.

All individuals to whom this section applies must be lawfully present in the United States.

*(This section is modified in section 1001 of the Reconciliation Act)*

**Subpart B - Eligibility Determinations**

**Section 1411. Procedures for Determining Eligibility for Exchange Participation, Premium Tax Credits and Reduced Cost-Sharing, and Individual Responsibility Exemptions**

The Secretary will establish a program to determine if an individual meets Internal Revenue Service (IRS) requirements, income requirements, and legal residency requirements to:

- Be covered in the individual market by a qualified health plan offered through an Exchange;
- Claim a premium tax credit; or
- Claim reduced cost-sharing.

The determination will be made based upon whether the individual is a citizen or legal resident, meets income requirements, whether the individual's coverage under an employer is considered unaffordable, and whether an individual is entitled to an exemption from the individual responsibility requirement.

An individual seeking exemption from any requirement or penalty must submit information on the individual's status as:

- A member of an exempt religious sect or division;
- A member of a health care sharing ministry;
- An American Indian; or
- Seeking a hardship exemption.

An Exchange will submit information provided by an applicant to the Secretary for verification with an appeals process and all applicant information will be confidential. There will be a penalty up to $250,000 for providing false or fraudulent information.

**Section 1412. Advanced Determination and Payment of Premium Tax Credits and Cost-Sharing Reductions**

The Secretary, with the Secretary of the Treasury, will establish a program that allows for the advanced payments of premium assistance tax credits and cost-sharing reductions for eligible individuals.

**Section 1413. Streamlining of Procedures for Enrollment through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs**

The Secretary will establish a system for residents in each State to apply for and receive a determination of eligibility to participate in applicable State health subsidy programs, including State Medicaid, State children's health insurance program, and a State program under section 1331.

The Secretary will develop and provide each State a single, streamlined form that may be used for all applicable State health subsidy programs within the State. The form may be filed online, in person, by

mail, telephone, or with an Exchange or State officials operating one of the subsidy programs. A State may develop its own form if it meets the same standards as the one provided by the Secretary.

Each State will develop a secure electronic interface allowing an exchange of data for all applicable State health subsidy programs. Each applicable State health subsidy program will:

- Participate in a data matching arrangement for determining eligibility for participation in the program;
- Establish, verify, and update eligibility criteria for participation in the program using the data matching system; and
- Determine such eligibility.

**Section 1414. Disclosures to Carry Out Eligibility Requirements for Certain Programs**

The Secretary of the Treasury, upon request from the Secretary, will disclose return information for taxpayers whose income is relevant in determining any premium tax credit or cost-sharing reduction, or eligibility for State Medicaid, State Children's Health Insurance Program, or a basic health program under section 1331. Return information may be used only for the purposes of establishing eligibility for participation in the Exchange, verifying the appropriate amount of any credit or reduction, and determining eligibility for participating in a State program.

**Section 1415. Premium Tax Credit and Cost-Sharing Reduction Payments Disregarded for Federal and Federally Funded Assistance Programs**

Any credit or refund made to an individual will not be considered income when determining that individual's eligibility for benefits in a State or Federal program that is funded by Federal funds. Any cost-sharing reduction payment or advance payment of the credit allowed will be treated as made to the qualified health plan and not to that individual.

## Part II - Small Business Tax Credit

**Section 1421. Credit for Employee Health Insurance Expenses of Small Businesses**

The small employer health insurance credit is equal to 50 percent (35 percent for tax-exempt small employers) of the lesser of either:

- The aggregate amount of nonelective contributions the employer made on behalf its employees for premiums for qualified health plans offered by the employer through an Exchange; or
- The aggregate amount of nonelective contributions that the employer would have made if each employee had enrolled in a qualified health plan with a premium equal to the average premium in the small group market.

The amount of the credit will be reduced by the sum of the following amounts:

- Health insurance credit × (Number of full-time equivalent employees in excess of 10 ÷ 15); and
- Health insurance credit × (Average annual wages in excess of *~~$20,000~~** ÷ *~~$20,000~~**).
  ** From 2011-2013 the dollar amount for these taxable years is ~~$20,000~~. In subsequent years the dollar amount will be ~~$20,000~~ multiplied by the cost-of-living adjustment.*

An eligible small employer is an employer with:

- No more than 25 full-time equivalent employees;
- Average annual wages that do not exceed two times the dollar amount specified above for the calendar year; and

- An arrangement where the employer makes a nonelective contribution of at least 50 percent of the premium cost on behalf of each employee who enters into a qualified health plan offered by the employer through an Exchange.

The hours and wages of seasonal workers will not be taken into account in determining full-time equivalent employees or average annual wages of the employer.

*(This section is modified in section 10105)*

## Subtitle F - Shared Responsibility for Health Care

### Part I - Individual Responsibility

### Section 1501. Requirement to Manage Minimum Essential Coverage

Congress makes the following findings:

- *The individual responsibility requirement provided in this section is commercial and economic in nature and substantially affects interstate commerce*;
- Health insurance and health care is a significant part of the economy and health spending is projected to increase from $2.5 trillion to $4.7 trillion in 2019;
- Requiring individuals to have coverage will add millions of new consumers, increasing supply of and demand for health care services;
- The requirement achieves near-universal coverage by building on the private employer-based health insurance system;
- *Given that half of all personal bankruptcies are caused in part by medical expenses, this requirement will improve financial security;*
- The requirement is essential to creating effective health insurance markets in which improved health insurance products are guaranteed issue and do not exclude pre-existing conditions can be sold; and
- By increasing coverage and the size of purchasing pools, economies of scale increase and administrative costs will be reduced.

After 2013, an applicable individual will ensure that the individual, and any dependent, has minimum essential coverage. Failure to meet the requirement for 1 or more months after 2013 will result in a penalty. Any penalty must be included with a taxpayer's return.

*The penalty for an individual for any month is an amount equal to 1/12 of the applicable dollar amount for the year. The penalty for any taxpayer for a taxable year, with respect to all individuals for whom the taxpayer is liable, will not exceed an amount equal to 300 percent the applicable dollar amount.* The applicable dollar amount is phased in at $95 for 2014, *$325 for 2015* and *$695* for 2016. In subsequent years the applicable dollar amount will be increased by an amount equal to:

- *$695 + ($695 × Cost of living adjustment)*.

An applicable individual does not include individuals who:

- Are members of a health care sharing ministry;
- Are not lawfully present; or
- Are incarcerated.

No penalty will be imposed on an individual who cannot afford coverage, generally if an individual's required contribution exceeds 8 percent of household income. No penalty will be imposed on *individuals below the tax filing threshold*, members of Indian tribes, an individual with less than a 3-month gap in coverage, and those who have received a hardship waiver.

*(This section is modified in section 10106)*
*(This section is further modified in section 1002 of the Reconciliation Act)*

**Section 1502. Reporting of Health Insurance Coverage**

The Internal Revenue Code is amended to require the reporting of minimum essential coverage by individuals, employers, and governmental units. By June 30 of each year, the Secretary of the Treasury will notify individuals who file tax returns if they are found to be lacking minimum essential coverage. This notification will include information of services available through an Exchange.

These amendments will be effective calendar years beginning after 2013.

**Part II - Employer Responsibilities**

**Section 1511. Automatic Enrollment for Employees of Larger Employers**

An employer with more than 200 full-time employees that offers enrollment in 1 or more health benefits plans will automatically enroll new full-time employees in one of the plans offered. An employee may opt out of any coverage automatically enrolled in.

**Section 1512. Employer Requirement to Inform Employees of Coverage**

By March 1, 2013, employers will provide each employee written notice:

- Of the existence of an Exchange, the services provided by the Exchange, and ways for requesting assistance with the Exchange;
- If the employer plan's share of the total allowed costs of benefits is less than 60 percent, the employee may be eligible for a premium tax credit; and
- If an employee purchases a plan through the Exchange, the employee will lose the employer contribution to any plan offered by the employer. The amount of those contributions may be excludable from income for tax purposes.

**Section 1513. Shared Responsibility for Employers**

If any applicable large employer does not offer full-time employees minimum essential coverage and has at least one full-time employee enrolled in a health plan with premium tax credits or cost-sharing reductions, then the employer is assessed a fee equal to:

- Applicable payment amount × (Number of full-time employees – the first 30 employees).

If an applicable large employer offers full-time employees the opportunity to enroll in an employer-sponsored pan and 1 or more full-time employees receive a premium tax credit or cost-sharing reduction, the employer will be assessed a fee.

An applicable large employer has an average of 50 or more full-time employees on business days during a calendar year.

*(This section is modified in section 1003 of the Reconciliation Act)*

**Section 1514. Reporting of Employer Health Insurance Coverage**

Applicable large employers will report information about the employer, employees receiving coverage, coverage offered, and length of any waiting period to the Secretary. Each employee whose information is required to be reported will be notified of the contact information of the person required to make the return and the information about the individual in the return. This will be effective after December 31, 2013.

**Section 1515. Offering of Exchange Participation Qualified Health Plans Through Cafeteria Plans**

The Internal Revenue Code is amended so that plans provided through the Exchange will not be eligible under an employer-sponsored cafeteria plan. This does not apply to any employee whose employer offers the opportunity to enroll in a qualified health plan through an Exchange.

## Subtitle G - Miscellaneous Provisions

**Section 1551. Definitions**

Unless otherwise specified, the definitions in section 2701 of the Public Health Service Act apply to this title.

**Section 1552. Transparency in Government**

Within 30 days of enactment, the Secretary will publish a list of all of the authorities of the Secretary on the Department of Health and Human Services (HHS) website.

**Section 1553. Prohibition Against Discrimination on Assisted Suicide**

Any Federal Government, State or local government or health care provider receiving Federal financial assistance under this Act or any health plan created under this Act may not discriminate against an individual or health care entity that does not provide any health care item or service for assisted suicide.

**Section 1554. Access to Therapies**

The Secretary may not establish procedures that:

- Creates unreasonable barriers to an individual's ability to obtain appropriate medical care;
- Impedes timely access to health care services;
- Interferes with communications regarding a full range of treatment options;
- Restricts the ability of health care providers to provide full disclosure of all relevant material for patients to make an informed decision;
- Violates the principles of informed consent; or
- Limits the availability of health care treatment for the duration of a patient's medical needs.

**Section 1555. Freedom Not to Participate in Federal Health Insurance Programs**

No individual, company, business, nonprofit entity, or health insurance issuer is required to participate in any Federal health insurance program created under this Act, and there will be to penalty for any issuer who chooses not to participate in such programs.

**Section 1556. Equity for Certain Eligible Survivors**

The Black Lung Benefits Act, which provides benefits to coal miners totally disabled by pneumoconiosis and to the surviving dependents of miners who died from the disease, will be extended.

**Section 1557. Nondiscrimination**

An individual will not be excluded from participation in, be denied benefits, or be subject to discrimination under any health program or activity that receives Federal assistance.

Nothing in this title limits the rights, remedies, procedures, or legal standards available to individuals in the Civil Rights Act of 1964, the Education Amendment of 1972, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, or to supersede State laws that provide additional protections.

**Section 1558. Protections for Employees**

No employer may fire an employee or discriminate against an employee on the basis that the employee has received a premium tax credit or has provided information, testified, and assisted in or refused to participate in a proceeding about a violation of this title.

**Section 1559. Oversight**

The Inspector General of the Department of Health and Human Services (HHS) has oversight authority with respect to the administration and implementation of this title as it relates to such Department.

**Section 1560. Rules of Construction**

Nothing in this title modifies, impairs or supersedes the operation of anti-trust laws. Nothing in this title modifies or limits the application of the exemption for Hawaii's Prepaid Health Care Act. Nothing in this title prohibits institutions of higher education from offering a student health insurance plan. Nothing in this title modifies any existing Federal requirements concerning State agency responsible for determining eligibility for program in section 1413.

**Section 1561. Health Information Technology Enrollment Standards and Protocols**

Within 180 days of enactment of this Act, the Secretary will develop interoperable and secure standards and protocols for enrolling individuals in Federal and State health and human services program. This will include providing individuals and third parties notifications of eligibility. The standards and protocols will include:

- Electronic matching of existing Federal and State data related to eligibility requirements;
- Simplification and submission of electronic documentation, digitization of documents, and system verification of eligibility;
- Reuse of stored eligibility information to help with retention;
- Capability for individuals to apply, recertify, and manage their eligibility information online;

- Ability to expand the enrollment system to integrate new programs, rule and functions; and
- Notification of eligibility and recertification through email and cell phones.

The Secretary will notify States of these standards or protocols and may require States or other entities to implement these standards before receiving Federal funds for health information technology (HIT) investments.

The Secretary will make grants available to develop new and adapt existing technology systems to implement the HIT enrollment standards and protocols. To be eligible for a grant, an entity must be a State or local government entity and submit a plan to the Secretary for adopting and implementing appropriate technology. The Secretary will make sure appropriate enrollment HIT adopted under these grants is shared with other appropriate qualified entities.

**Section 1562. Conforming Amendments**

This section contains technical and conforming amendments.

**Section 1563. Sense of the Senate Promoting Fiscal Responsibility**

The Senate makes the following findings:

- Based on Congressional Budget Office (CBO) estimates this Act will reduce the Federal deficit between 2010 and 2019;
- CBO projects this act will reduce budget deficits after 2019;
- Based on CBO estimates, this Act will extend the solvency of the Medicare Hospital Insurance Trust Fund;
- This Act will increase the surplus in the Social Security Trust Fund; and
- Initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of the program.

# Title II - Role of Public Programs

## Subtitle A - Improved Access to Medicaid

**Section 2001. Medicaid Coverage for the Lowest Income Populations**

Beginning on January 1, 2014, a State Medicaid program must make medical assistance available to individuals with income at or below 133 percent of the poverty line who are under age 65, not pregnant, or not entitled to or enrolled in Medicare. Medical assistance will consist of benchmark or benchmark equivalent coverage.

From January 1, 2014 to December 31, 2016, the Federal medical assistance percentage (FMAP) to States for amounts spent on medical assistance for newly eligible individuals below 133 percent of the poverty line will be 100 percent. In 2017 and succeeding years the FMAP will not exceed 95 percent.

*From January 1, 2011* through January 1, 2014, a State may elect to provide medical assistance to individuals age 19 and up who would become eligible for coverage in 2014, and a State may phase-in such enrollment based on income. If an individual is a parent, their child must be enrolled in Medicaid or

other health insurance coverage before the individual can enroll. A State may elect to provide a presumptive eligibility period for newly eligible individuals.

In order to receive Federal payments under section 1903 of the Social Security Act, from the date of enactment of this Act until the date the Secretary determines an Exchange is fully operational, a State may not enact eligibility standards or procedures that are more restrictive than those in effect at the date of enactment of this Act. Between January 1, 2011 and January 1, 2014, if a State certifies a budget deficit, then the State may be exempt from this requirement for non-pregnant, nondisabled adult populations whose family income is above 133 percent of the poverty line.

Beginning January 1, 2014, any Medicaid benchmark coverage must provide at least essential health benefits. The entity offering benchmark coverage must ensure parity of mental health services. Beginning January 2015, the State must provide an annual report on Medicaid enrollment, outreach and enrollment processes, and any additional data requested to the Secretary.

Beginning January 1, 2014, a State may elect to provide coverage individuals under age 65 with income above 133 percent of the poverty line, as long as this does not exceed the highest income eligibility under the State plan, and phase-in such coverage based on income.

*(This section is modified in section 10201)*
*(This section is further modified in section 1201 of the Reconciliation Act)*

**Section 2002. Income Eligibility for Nonelderly Determined Using Modified Gross Income**

In determining the eligibility for Medicaid and cost-sharing, a State will use the modified gross income of an individual or household and no assets test may be used to determine eligibility. The following groups are exempt from this: individuals eligible for the State plan not based on income (e.g. foster children), those over age 65, and those who qualify on the basis of being blind or disabled. Express lane eligibility, Medicare prescription drug subsidies, and long-term care are not affected by this.

Individuals already enrolled in a Medicaid program on January 1, 2014 may be grandfathered in through March 31, 2014, or the date scheduled for the individual's redetermination of eligibility.

Each State will submit proposed income eligibility thresholds to the Secretary for approval.

**Section 2003. Requirements to Offer Premium Assistance for Employer-Sponsored Insurance**

A State will offer a premium assistance subsidy for employer-sponsored coverage to all individuals eligible for a State plan (Medicaid or CHIP) who have access to such coverage. Effective date is January 1, 2014.

**Section 2004. Medicaid Coverage for Former Foster Care Children**

*Individuals who were in foster care in a State for more than 6 months and are under age 25 will qualify for Medicaid.* The effective date for this is *January 1, 2019.*

*(This section is modified in section 10201)*

**Section 2005. Payments to Territories**

FMAP for these territories will be increased to 55 percent on July 1, 2010.

*(This section is modified in section 1204 of the Reconciliation Act)*

**Section 2006. Special Adjustment to FMAP Determination for Certain States Recovering From a Major Disaster**

The disaster recovery adjustment for Federal Medical Assistance Percentage will be increased by 50 percent in the first year after a disaster and by 25 percent in the second or any succeeding years.

**Section 2007. Medicaid Improvement Fund Rescission**

Any amount made available to the Medicaid Improvement Fund for 2014 through 2018 is rescinded.

## Subtitle B - Enhanced Support for the Children's Health Insurance Program

**Section 2101. Additional Federal Financial Participation for CHIP**

Between *October 1, 2013* and September 30, 2019, the enhanced FMAP for CHIP determined for a State will be increased by 23 percentage points and will not exceed 100 percent. States must maintain current CHIP eligibility requirements through 2019.

*In case funding is insufficient to cover all eligible children through CHIP, the State will establish a procedure to cover these children through an Exchange.*

Beginning January 1, 2014, the State will use adjusted gross income to determine eligibility and cost-sharing for CHIP. A State will provide CHIP coverage to children deemed ineligible for State Medicaid as a result of the elimination of the application of an income disregard.

*(This section is modified in section 10201 and 10203)*

**Section 2102. Technical Corrections**

Allotments in fiscal year 2010 for providing CHIP are increased to an amount equal to the Federal share of expenditures under the enhanced FMAP rate.

## Subtitle C - Medicaid and CHIP Enrollment Simplification

**Section 2201. Enrollment Simplification and Coordination with State Health Insurance Exchanges**

By January 1, 2014, a State will establish procedures for:

- Individuals to apply, enroll or renew enrollment in a state plan through a website;
- Enrolling individuals identified by an Exchange in Medicaid or CHIP through the website with no further determination by the State;
- Ensuring individuals not eligible for Medicaid or CHIP are screened for eligibility in a plan offered through an Exchange and premium assistance if applicable;
- Ensuring State agencies responsible for Medicaid, CHIP, and an Exchange use a secure electronic interface for these procedures;

- Coordinating medical assistance or child health assistance for individuals enrolled in both Medicaid and a qualified health plan in an Exchange or CHIP and a qualified health plan in an Exchange; and
- Conducting outreach to vulnerable and underserved populations eligible for Medicaid or CHIP.

The State Medicaid agency and State CHIP agency may enter into agreements with an Exchange to determine a State resident's eligibility for premium assistance to purchase a qualified health plan. The State Medicaid agency and State CHIP agency must participate in and comply with requirements for the system described in section 1413.

By January 1, 2014, the State must have operational a website to compare benefits, premiums, and cost-sharing applicable to an individual under the State plan (Medicaid or CHIP) with those under an available qualified health plan through an Exchange.

**Section 2202. Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Patients**

Any hospital that is a participating provider in a State plan may elect to be a qualified entity to determine, on the basis of preliminary information, whether an individual is eligible for medical assistance under Medicaid. Effective date is January 1, 2014.

## Subtitle D - Improvements to Medicaid Services

**Section 2301. Coverage for Freestanding Birth Center Services**

Medicaid will cover freestanding birth center services and other ambulatory services offered by freestanding birth centers, effective on the date of enactment of this Act. A State will provide separate payments to providers who offer care in a freestanding birth center, such as nurse midwives, birth attendants and other providers as recognized under State law.

**Section 2302. Concurrent Care for Children**

Children who are enrolled in either Medicaid or CHIP may receive hospice services without giving up the right to receive treatment where a diagnosis of terminal illness has been made.

**Section 2303. State Eligibility Option for Family Planning Services**

Individuals who are not pregnant and meet certain income requirements may be eligible for Medicaid services for family planning, including medical diagnosis and treatment services. A State also has the option to include individuals eligible under the standards and processes of existing section 1115 waivers. This is effective on the date of enactment of this Act.

**Section 2304. Clarification of Definition of Medical Assistance**

Clarifying language is specified for section 1905(a) of the Social Security Act.

## Subtitle E - New Options for States to Provide Long-Term Services and Supports

### Section 2401. Community First Choice Option

Beginning October 1, 2011, a State may provide medical assistance for home and community-based attendant services and supports through a State plan amendment. Services would be for individuals with income below 150 percent of the poverty line and who would otherwise require a level of care provided in a hospital, nursing home, facility for the mentally retarded, or institution for mental diseases, which would be paid through Medicaid.

Such services and supports to accomplish activities of daily living and health related tasks will be made available by the State through a person-centered plan of services and supports, in a home or community setting, under an agency-provider model which is selected, managed, and dismissed by the individual. The Federal Medical Assistance Percentage for the State to carry this out will be increased by 6 percentage points.

In order for a State plan amendment to be approved, the State will:

- Develop and implement the amendment with a Development and Implementation Council established by the State;
- Provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis;
- Maintain or exceed the level of State expenditures for medical assistance provided from the previous year;
- Establish and maintain a comprehensive and continuous quality assurance system that includes:
    - Standards for training, appeals and denials for agencies;
    - Feedback from consumers and their representatives;
    - Monitors for the health wellness of each individual; and
    - Provides information about quality assurance.
- Collect and report information to the Secretary.

The Secretary will evaluate the provision of home and community-based services to determine their effectiveness and impact on individuals and a cost comparison between such services and those provided under institutional care.

The State will provide the Secretary the following information each fiscal year services and supports are provided:

- Number of individuals who receive home and community-based services and supports;
- Number of individuals who received services the previous year;
- Number of individuals served by type of disability, age, gender, education level and employment status; and
- Whether the individuals have been previously served under any other home and community-based services program under the State plan.

*(This section is modified in section 1205 of the Reconciliation Act)*

**Section 2402. Removal of Barriers to Providing Home and Community-Based Services**

The Secretary will ensure that all States develop service systems that:

- Allocate resources in a way that is responsive to the changing needs and choices of people receiving non-institutionally-based long-term services and supports and provides strategies for beneficiaries receiving such services to maximize their independence;
- Provide support and coordination needed for a beneficiary in need of such services; and
- Improve coordination among, and regulation of, all providers to have more consistent administration and oversee and monitor all services.

A State may elect to provide home and community-based services to individuals whose income is less than 300 percent of the supplemental security income benefit rate, and services may differ in type, amount, duration or scope. The State may also elect to target the provision of home and community-based services to specific populations and to differ the type, amount, duration, or scope of such services to such populations for a period of 5 years.

**Section 2403. Money Follows the Person Rebalancing Demonstration**

The Money Follows the Person Rebalancing Demonstration will continue through 2016, and the institutional residency period is reduced to not less than 90 consecutive days. This is effective 30 days after the date of enactment of this Act.

**Section 2404. Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment**

States must apply spousal impoverishment rules to beneficiaries who receive home and community-based services starting January 1, 2014 for 5 years.

**Section 2405. Funding to Expand State Aging and Disability Resource Centers**

This Act makes available $10 million to the Secretary for each fiscal year from 2010 through 2014 for Aging and Disability Resource Centers.

**Section 2406. Sense of the Senate Regarding Long-Term Care**

The Senate makes the following findings:

- It has been 20 years since Congress considered long-term care reform;
- Individuals with disabilities have the right to receive long-term services and supports in the community based on the Olmstead decision; and
- In 2007, 69 percent of Medicaid long-term care spending for elderly adults and adults with physical disabilities paid for institutional services.

It is the sense of the Senate that Congress should address long-term services and supports in a comprehensive way, and such supports should be made available in the community in addition to in institutions.

## Subtitle F - Medicaid Prescription Drug Coverage

### Section 2501. Prescription Drug Rebates

After December 31, 2009, the minimum percentage for single source drugs and innovator multiple source drugs will be 23.1 percent. The rebate for clotting factors and drugs approved by the Food and Drug Administration (FDA) for pediatric indications will be 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs will be 13 percent.

There will be an extension of prescription drug discounts on outpatient drugs for Medicaid patients enrolled in a Medicaid managed care organization.

In the case of a new formulation for a drug, the rebate will be the amount computed under this section, or if greater, the average manufacturer price for each dosage of the new formulation multiplied by the highest additional rebate of the original drug multiplied by the total number of units of each dosage of the new formulation paid by Medicaid in the rebate period. Effective for drugs paid for by a State after December 31, 2009.

Rebates for a single source drug or innovator multiple source drug will not exceed 100 percent of the average manufacturer price of the drug for a rebate period beginning after December 31, 2009.

### Section 2502. Elimination of Exclusion of Coverage of Certain Drugs

Drugs used to promote smoking cessation, barbiturates, and benzodiazepines will not be excluded from coverage effective on services provided after January 1, 2014.

### Section 2503. Providing Adequate Pharmacy Reimbursement

The Secretary will calculate the Federal upper reimbursement limit as no less than 175 percent of the weighted average of the most recently reported monthly average manufacturer prices for drug products available for purchase by retail community pharmacies nationwide.

The average manufacturer price for a covered outpatient drug will exclude:

- Prompt payment discounts, service fees, and reimbursement by manufacturers; and
- Payments received from and rebates or discounts provided to pharmacy benefit managers, managed care organizations, insurers, providers, and manufacturers.

## Subtitle G - Medicaid Disproportionate Share Hospital Payments

### Section 2551. Disproportionate Share Hospital Payments

*Effective October 1, 2011, the Disproportionate Share Hospital (DSH) allotment for a State will be reduced by 25 percent in a low DSH State and by 50 percent in all other States in the first fiscal year after 2012 where the uninsured rate in the State is 45 percent less than the rate in 2009. In subsequent fiscal years, DSH payments will be reduced by:*

- *In low DSH State- Percentage reduction in uninsured from previous fiscal year × 25 percent; and*
- *All other States- Percentage reduction in uninsured from previous fiscal year × 50 percent.*

*(This section is modified in section 10201)*

## Subtitle H - Improved Coordination for Dual Eligible Beneficiaries

### Section 2601. 5-year Period for Demonstration Projects

Waivers to provide medical assistance to dual eligible individuals may be conducted for 5 years and may be extended for an additional 5-year period. Dual eligible individuals are those who are entitled to benefits in Medicare and Medicaid.

### Section 2602. Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

By March 1, 2010, the Secretary will establish a Federal Coordinated Health Care Office within CMS to integrate the benefits under the Medicare and Medicaid programs and improve coordination between the Federal Government and States. The goals of this office are:

- Providing dual eligible individuals full access to benefits they are entitled under the Medicare and Medicaid programs;
- Simplifying the process for dual eligible individuals to access items and services;
- Improving the quality of health care and long-term services;
- Increasing dual eligible individuals' understanding and satisfaction with coverage;
- Eliminating regulatory conflicts;
- Improving continuity and ensuring safe and effective care transitions;
- Eliminating cost-shifting between the Medicare and Medicaid programs and among related health care providers; and
- Improving the quality of performance of providers of services and supplies.

Specific responsibilities of the Federal Coordinated Health Care Office are:

- Providing States, physicians, and relevant entities with education and tools for developing programs to align benefits for dual eligible individuals;
- Supporting State efforts to coordinate acute and long-term care services with services provided under Medicare;
- Providing support for coordination of contracting and oversight;
- To consult and coordinate with the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission; and
- To study the provision of drug coverage for dual eligible individuals and monitor and report annual expenditures, health outcomes, and access to benefits.

## Subtitle I - Improving the Quality of Medicaid for Patients and Providers

### Section 2701. Adult Health Quality Measures

The Secretary will identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults. An initial set of health quality measures will be published by January 1, 2012. By January 1, 2013, in consultation with States, a standardized format for reporting on these quality measures will be developed and a procedure created to encourage States to use the measures.

The Secretary will establish a Medicaid Quality Measurement Program, which will provide grants for the development, testing and validation of emerging and innovative evidence-based measures. Within 2 years of this and then annually, the Secretary will publish recommended changes to the initial core set of

measures based on the testing, validation, and consensus process. This Act makes available $60 million for each fiscal year between 2010 and 2014 to carry out the provisions of this title.

**Section 2702. Payment Adjustment for Health Care Acquired Conditions**

The Secretary will identify current State practices that prohibit payment for health care-acquired conditions and incorporate these in regulations to the Medicaid program to be effective July 1, 2011. The Secretary will prohibit payments to States for services related to a health care-acquired condition, such that no beneficiaries are denied access to care or services.

**Section 2703. State Option to Provide Health Homes for Enrollees with Chronic Conditions**

Beginning January 1, 2011, a State has the option to provide medical assistance to eligible individuals with chronic conditions who select a designated provider or a health team as the individual's health home. The Secretary will establish standards for qualification for being eligible to be a health home. For the first 8 fiscal year quarters that a State plan has this in effect, the Federal Medical Assistance Percentage for payments will be 90 percent.

The Secretary will award planning grants to States to develop a State plan amendment for this beginning January 1, 2011. Grants to States will not exceed $25 million.

A State will include a requirement for hospitals participating in Medicaid to establish procedures for referring eligible beneficiaries to designated providers. A State will consult and coordinate with the Substance Abuse and Mental Health Services Administration regarding the prevention and treatment of mental illness and substance abuse. A State will include in their plan amendment:

- Methodology for tracking avoidable hospital readmissions and calculating savings from improved chronic care coordination; and
- A proposal for using health information technology in providing health home services and improving service and coordination across the care continuum.

Health home services are comprehensive and timely high-quality services provided by a designated provider, a team of health care professional operating with such provider, or a health team. Services include: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of health information technology to link services.

**Section 2704. Demonstration Project to Evaluate Integrated Care around a Hospitalization**

The Secretary will establish a demonstration project to evaluate the use of bundled payments to provide integrated care to a Medicaid beneficiary. Demonstrations projects will run from January 1, 2012 through December 31, 2016 in up to 8 states. The demonstration project will focus on conditions where providers may improve the quality of care while reducing total expenditures under Medicaid.

A participating State will specify 1 or more episodes of care to address in the project, the services included in bundled payments, and the rationale for the selection. States will ensure Medicaid beneficiaries are not liable for any additional cost-sharing. The Secretary and each participating State will ensure that Medicaid beneficiaries in the demonstration project do not receive less items and services than if they had been in the Medicaid program without the demonstration project.

**Section 2705. Medicaid Global Payment System Demonstration Project**

The Secretary with the Center for Medicare and Medicaid Innovation will establish the Medicaid Global Payment System Demonstration Project. This project will allow up to 5 States to adjust payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model between 2010 and 2012.

**Section 2706. Pediatric Accountable Care Organization Discretion Project**

The Secretary will establish the Pediatric Accountable Care Organization Demonstration Project which authorizes a participating State to allow pediatric medical providers that meet requirements to be recognized as an accountable care organization in order to receive incentive payments. The demonstration project will run from January 1, 2012 through December 31, 2016.

A State must submit an application that establishes:

- Guidelines to ensure quality of care is at least the same as would have otherwise been provided;
- An annual minimal level of savings in Medicaid and CHIP programs that must be reached by an accountable care organization to receive an incentive payment; and
- An agreement between providers and the State for at least 3 years of participation.

**Section 2707. Medicaid Emergency Psychiatric Demonstration Project**

The Secretary will establish a demonstration project under which an eligible State provides payment under the State Medicaid plan to an institution for mental diseases that is not publicly owned or operated. Such an institution would serve individuals who were ages 21 to 65, are eligible for Medicaid, and require medical assistance to stabilize an emergency medical condition.

A State will specify a mechanism for how it will ensure participating institutions will determine if an individual has been stabilized before the third day of an inpatient stay. An eligible State will submit an application as required by the Secretary and be selected on a competitive basis.

The demonstration project will run for 3 years. For fiscal year 2011 $75 million is appropriated for this project and will be available for obligation through December 31, 2015. The Secretary will conduct an evaluation of the demonstration project.

## Subtitle J - Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

**Section 2801. MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries**

Medicaid and CHIP Payment Access Commission (MACPAC) will review and assess Medicaid and CHIP eligibility policies, enrollment and retention processes, benefit and coverage policies, policies as they relate to the quality of care provided under those programs. MACPAC will also review and assess the interaction of policies under Medicaid and Medicare with respect to how interactions affect access to services, payments, and dual eligible individuals.

MACPAC will review national and State-specific Medicaid and CHIP data and submit reports and recommendations to Congress, the Secretary, and States. MACPAC will consult with the Medicare

Payment Advisory Commission (MedPAC) as appropriate and each will share information upon request with the other entity. This Act makes available $11 million for MACPAC for fiscal year 2010.

## Subtitle K - Protections for American Indians and Alaska Natives

### Section 2901. Special Rules Relating to Indians

There will be no cost-sharing for Indians below 300 percent of the poverty line covered through a State Exchange. Health programs operated by the Indian Health Service, Indian tribes, tribal organizations and Urban Indian organizations will be the payers of last resort for services to individuals eligible for such services.

### Section 2902. Elimination of Sunset for Reimbursement for All Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics

This section allows Medicare Part B to pay a hospital or ambulatory care clinic operated by the Indian Health Service, an Indian tribe, or a tribal organization for services by removing the sunset provision in section 1880 the Social Security Act, effective January 1, 2010.

## Subtitle L - Maternal and Child Health Services

### Section 2951. Maternal, Infant, and Early Childhood Home Visiting Programs

The purposes of this section are to strengthen and improve the programs and activities carried out under this title, to improve coordination of services for at risk communities, and to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

Within 6 months of enactment of this Act, each State must conduct a statewide needs assessment that identifies:

- Communities with concentrations of premature birth, low-birth weight infants, and infant mortality; poverty; crime; domestic violence; high rates of high school drop-outs; substance abuse; unemployment; or child maltreatment;
- The quality and capacity of existing programs or initiatives for early childhood visitation in the State; and
- The State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such services.

The State will coordinate with other appropriate needs assessments conducted by State. Each State will submit the results of the assessment to the Secretary and a description of how the State intends to address needs identified, which may include applying for a grant.

The Secretary will make grants available to eligible entities to deliver services under early childhood home visitation programs to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, the socioeconomic status of families, and reductions in child abuse, neglect and injuries.

An eligible entity may use a portion of funds in the first 6 months of the grant for planning or implementation activities to assist with the establishment of early childhood home visitation programs. The Secretary will provide technical assistance.

The requirements for an early childhood home visitation program conducted with a grant include the eligible entity establishes quantifiable, measurable 3- and 5-year benchmarks for demonstrating improvements in:

- Improved maternal and newborn health;
- Prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency; and
- Improvements in the coordination and referrals for other community resources and supports.

An eligible entity must submit a report after the third year of the program. If the entity fails to demonstrate improvements in at least 4 areas, the entity must develop and implement a plan to improve outcomes, with technical assistance made available by the Secretary.

The program must include the use of 1 or more service delivery models (evidence-based or promising strategy), employ well-trained and competent staff, demonstrate strong organizational capacity, establish appropriate links and referral networks to other community resources, and give priority to high-risk populations.

An eligible entity must submit an application which includes:

- A description of the population to be served;
- An assurance that priority will be given to low-income eligible families and eligible families residing in at-risk communities;
- The service deliver model or models to be used;
- A statement identifying consistencies with the statewide needs assessment;
- Assurances the entity will submit annual reports; and
- A description of other State programs that include home visitation.

Funds provided in a grant under this section will supplement and not supplant funds from other sources for early childhood home visitation programs or initiatives. The Secretary will conduct an evaluation of the statewide needs assessments based on recommendations from an advisory council, including a State-by-State analysis.

The Secretary will ensure the Maternal and Child Health Bureau and the Administration for Children and families collaborate on reviewing and analyzing statewide needs and consult with other Federal agencies responsible for administering or evaluating programs that serve eligible families.

The Secretary will specify requirements for eligible entities that are Indian Tribes, Tribal Organizations or Urban Indian Organizations. If at the beginning of fiscal year 2012, a State has not applied or been approved for a grant, the Secretary may make a grant available to an eligible entity that is a nonprofit organization to provide an early childhood home visitation program the State.

The Secretary will carry out a continuous program of research and evaluation activities regarding the effectiveness of home visitation programs, and submit a report to Congress by December 31, 2015. There

will be $100 million allocated for 2010, $250 million for 2011, $350 million for 2012, $400 million for 2013, and $400 million for 2014. Any funds not expended may be used for grants to nonprofits.

**Section 2952. Support, Education and Research for Postpartum Depression**

The Secretary will continue activities on postpartum depression or postpartum psychosis, including:

- Research on the causes of the conditions;
- Epidemiological studies to address the frequency and history of the conditions and the differences among racial and ethnic groups;
- The development of improved screening and diagnostic techniques;
- Clinical research for the development and evaluation of new treatments; and
- Information and education programs for health care professionals and the public.

It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study of the relative mental health consequences for women of resolving a pregnancy in various ways and submit a report on the findings to Congress.

The Secretary may make grants available to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families. The Secretary may integrate this grant program with other grant programs.

There are appropriate $3 million for fiscal year 2010, and such sums as may be needed for fiscal years 2011 and 2012. The Secretary will conduct a study on the benefits of screening for postpartum conditions and submit a report on the results to Congress.

**Section 2953. Personal Responsibility Education**

For each fiscal year 2010 through 2014, the Secretary will allot to each State at least $250,000 to carry out personal responsibility education programs. A State must submit an application to receive funds which includes:

- The most recent pregnancy rates for ages 10-14 and 15-19, the most recent birth rates for such populations, and the trends in those rates;
- State-established goals for reducing pregnancy and birth rates in such youth populations; and
- A description of the State's plan for using the State allotments to achieve these goals.

If a State does not submit an application for fiscal year 2010 or 2011, the State will not be eligible for funds for fiscal years 2010 through 2014. The Secretary will ask for applications for 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct programs and activities in States that do not submit an application in 2010 or 2011. No payment will be made to a State or local organization, if the State or local organization will spend less with the allotment or grant on programs and initiative than they did in 2009 with non-Federal funds.

Personal responsibility education programs are designed to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections and at least 3 of the adulthood preparation subjects. The program must:

- Replicate evidence-based effective programs;
- Be medically-accurate and complete;
- Include activities to educate youth who are sexually active regarding responsible sexual behavior;
- Place substantial emphasis on both abstinence and contraception for the prevention of pregnancy;

- Provide age-appropriate information and activities; and
- Provide information and activities in the cultural context most appropriate for the population served.

Adulthood preparation subjects include healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and health life skills.

The Secretary will reserve $10 million for awarding grants to entities to implement such programs. Additional funds are reserved for awarding grants to Indian tribes and tribal organizations and for the Secretary to provide program support and evaluate programs.

**Section 2954. Restoration of Funding for Abstinence Education**

Section 510 of the Social Security Act is amended to restore funding for abstinence education for 2010 through 2014.

**Section 2955. Inclusion of Information About the Importance of Having A Health Care Power of Attorney in Transition Planning for Children Aging Out of Foster Care and Independent Living Programs**

A State must ensure that adolescents transitioning out of foster care or participating in independent living education programs will be provided with information about the importance of designating another individual to make health care treatment decisions on their behalf if they are unable to participate in such decisions and how to make such an arrangement. This is effective October 1, 2010.

# Title III - Improving the Quality and Efficiency of Health Care

## Subtitle A - Transforming the Health Care Delivery System

### Part I - Linking Payment to Quality Outcomes under the Medicare Program

**Section 3001. Hospital Value-Based Purchasing Program**

The Secretary will establish a hospital value-based purchasing program to begin in fiscal year 2013 where value-based incentive payments are made to hospitals that meet performance standards.

The Secretary will select the measures for the program, which will cover at least the following conditions or procedures: acute myocardial infarction, heart failure, pneumonia, surgeries, and health care-associated infection. Efficiency measures will be included for payments made in fiscal year 2014 and subsequent years. Measures for the program must be included on the Hospital Compare Internet website for at least 1 year prior to the performance period.

The Secretary will establish performance standards which will include levels of achievement and improvement. Performance standards will take into account:

- Practical experience with the measures involved;
- Historical performance standards;

- Improvement rates; and
- The opportunity for continued improvement.

The Secretary will develop a methodology to assess the total performance of each hospital based on performance standards and provide an assessment (hospital performance score) for each hospital for each performance period. Hospitals with the highest hospital performance scores will receive the largest value-based incentive payments. There will be no minimum performance standards in determining the hospital performance score, and the score will reflect measures that apply to the hospital.

The value-based incentive payment amount for each discharge of a hospital in a fiscal year is equal to the product of the base operating diagnosis-related group (DRG) payment and the value-based incentive payment percentage which the Secretary will specify.

The total amount available for incentive payments will be equal to the total amount of reduced DRG payments for all hospitals. The Secretary will reduce DRG payments by: 1 percent in fiscal year 2013; 1.25 percent in 2014; 1.5 percent in 2015; 1.75 percent 2016; and 2 percent in 2017 and succeeding fiscal years.

There are special rules for payments to a Medicare-dependent, small rural hospital or a sole community hospital. The Secretary will inform each hospital of the adjustments to payments no later than 60 days prior to the fiscal year involved. The Secretary will make information on hospital performance and the hospital performance score available to the public.

The Comptroller General of the United States will conduct a study of the performance of the hospital value-based purchasing program with an interim report to Congress by October 1, 2015 and a final report by July 1, 2017. The Secretary will conduct a study on the performance of the hospital value-based purchasing program and submit a report to Congress by January 1, 2016.

Within two years of the date of enactment of this Act, the Secretary will establish demonstration programs to establish a value-based purchasing program under Medicare for critical access hospitals and for inpatient hospital services to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals for 3 years. The demonstration program will be budget neutral and the Secretary will submit a report within 18 months of the completion of the demonstration program.

**Section 3002. Improvements to the Physician Quality Reporting System**

Incentive payments for quality reporting are extended through 2014. In 2015 and subsequent years, if an eligible professional does not satisfactorily submit data on quality measures, the fee schedule for provided services will reduced. An eligible professional may submit quality data through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets criteria.

By January 1, 2012, the Secretary will develop a plan to integrate reporting on quality measures under this section with reporting requirements relating to the meaningful use of electronic health records. The Secretary will provide timely feedback to eligible professionals regarding satisfactorily submitting data on quality measures.

**Section 3003. Improvements to the Physician Feedback Program**

The Secretary will use claims data to provide confidential reports to physicians that measure resources involved in furnishing care under Medicare. Reports may include information on the quality of care provided.

The Secretary will develop an episode grouper that combines separate but clinically related items and services into an episode of care by January 1, 2012. The Secretary will provide reports to physicians that compare patterns of resource use of the individual physician to those of other physicians beginning in 2012. The reports may be adjusted for socioeconomic and demographic characteristics, ethnicity, and health status of individuals. The Physician Feedback Program will be coordinated with other value-based purchasing reforms.

**Section 3004. Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs**

Beginning in 2014, if a long-term hospital, rehabilitation facility, or hospice program does not submit data on quality measures to the Secretary, the annual update to a standard Federal rate will be reduced by 2 percentage points. By October 1, 2012, the Secretary will publish measures applicable to rate year 2014. The submitted data will be made available to the public.

**Section 3005. Quality Reporting for PPS-Exempt Cancer Hospitals**

Starting in 2014, cancer hospitals must report data on quality measures to the Secretary. By October 1, 2012, the Secretary will publish measures applicable to fiscal year 2014. The submitted data will be made available to the public.

**Section 3006. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies**

The Secretary will develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities, which addresses:

- The ongoing development, selection, and modification process for measures of quality and efficiency in skilled nursing facilities;
- The reporting, collection, and validation of quality data;
- The structure of value-based payment adjustments; and
- Methods for public disclosure of information.

The Secretary will consult relevant affected parties and report the plan to Congress by October 1, 2011. The Secretary will develop a plan to implement a value-based purchasing program for Medicare payments for home health agencies in the same manner as above.

**Section 3007. Value-Based Payment Modifier under the Physician Fee Schedule**

The Secretary will establish a payment modifier that provides for different payments to a physician under the fee schedule based on the quality of care provided compared to cost. Quality of care will be evaluated based on appropriate measures set by the Secretary. Cost will be evaluated based on a composite of appropriate measures set by the Secretary, which take into account risk factors.

By January 1, 2012, the Secretary will publish measures of quality of care and costs, dates for implementation of the payment modifier, and the initial performance period.

The payment modifier will be applied for items and services provided to specific physicians beginning January 1, 2015 and will be applied to all physicians by January 1, 2017. The payment modifier will be:

- Implemented in a budget neutral manner;
- Applied in a manner that promotes systems-based care; and
- Will be coordinated with the Physician Feedback Program.

**Section 3008. Payment Adjustment for Conditions Acquired in Hospitals**

As an incentive to reduce hospital acquired conditions, payments under this section to applicable hospitals will be reduced by 1 percent beginning in fiscal year 2015. An applicable hospital is a hospital in the top quartile for hospital acquired conditions during the applicable period.

A hospital may be exempt if the State submits an annual report to the Secretary describing how a similar program in the State for a participating hospital achieves or surpasses the patient health outcomes and cost savings established under this section.

The Secretary will provide confidential reports to applicable hospitals regarding hospital acquired conditions prior to fiscal year 2015 and each subsequent fiscal year. Information on hospital acquired conditions will be made available to the public and applicable hospitals will have the opportunity to review and submit corrections on this information.

The Secretary will conduct a study on expanding the health care acquired conditions policy to Medicare payments to other facilities. The study will analyze how such policies could impact quality of patient care, patient safety, and spending under Medicare.

**Part II - National Strategy to Improve Health Care Quality**

**Section 3011. National Strategy**

The Secretary will establish a national strategy, through a collaborative process and based on national priorities, to improve the delivery of health care services, patient health outcomes, and population health. The priorities will:

- Have the greatest potential for improving health outcomes, efficiency, and patient-centeredness;
- Identify areas in the delivery system that have potential for rapid improvement;
- Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures, and data aggregation techniques;
- Improve Federal payment policy;
- Enhance the use of health care data;
- Address the health care provided to patients with high-cost chronic diseases;
- Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions, and health care-associated infections; and
- Reduce health disparities across populations and geographic areas.

The Secretary will develop the plan in consultation with State Medicaid and CHIP agencies. The national strategy will have a comprehensive strategic plan which includes:

- Coordination among agencies in HHS;
- Agency-specific strategic plans;

- Establishment of annual benchmarks for each agency;
- Strategies to align public and private payers regarding quality and patient safety efforts; and
- Incorporating quality improvement and measurement in the strategic plan for health information technology.

The Secretary will update the national strategy at least annually and by January 1, 2011, will submit the national strategy to Congress and post national priorities on an Internet website.

**Section 3012. Interagency Working Group on Health Care Quality**

The President will convene the Interagency Working Group on Health Care Quality. The goals of the group are to achieve: collaboration, cooperation, and consultation between departments with respect to developing and disseminating strategies, goals, models, and timetables consistent with the national priorities identified under section 3011. The Working Group will be composed of senior representatives of major health-related Federal Departments and will report progress and recommendations to Congress annually, beginning no later than December 31, 2010.

**Section 3013. Quality Measure Development**

Quality measures are a standard for measuring the performance and improvement of population health or of health plans, providers of services. The Secretary, the Director of the Agency for Health Care Research and the Administrator of CMS will identify gaps where no quality measures exist or are in need of improvement for Federal health programs at least every 3 years.

The Secretary will award grants or contracts to eligible entities to develop, improve, update, or expand quality measures identified with priority given to the development of certain quality measures. An entity receiving a grant or contract will develop quality measures that:

- Support measures required to be reported under the Social security Act;
- Support measures developed for Medicaid programs;
- Allows data on such measures to be collected using health information technologies;
- Is free of charge to users; and
- Is publicly available on an Internet website.

This Act authorizes $75 million for each fiscal year 2010 through 2014.

**Section 3014. Quality Measurement**

Multi-stakeholder groups will be convened to provide input on *quality measures* and national priorities. By February 1 of each year (beginning with 2012), the Secretary will be sent the input of multi-stakeholder groups.

The Secretary will consider input from multi-stakeholder groups in selecting *quality measures* and publish the rationale for any quality measures not endorsed by the entity. By March 1, 2012, and at least every 3 years, the Secretary will assess the *quality impact* of endorsed measures. The Secretary will establish a process for disseminating *quality measures* used and will review them at least once every 3 years.

Funds will be transferred from the Federal Hospital Insurance Trust fund and Federal Supplementary Medical Insurance Trust Fund for a total of $20 million in each fiscal year 2010 through 2014 for carrying out the amendments of this section.

*(This section is modified in section 10304)*

**Section 3015. Data Collection; Public Reporting**

The Secretary will collect and aggregate data on quality and resource use measures from information systems used in health care delivery for public reporting of performance information. The Secretary may award grants or contracts to eligible entities to support new or improve existing efforts and which enable data to be integrated and compared across multiple sources.

The entity must agree that it will match $1 of non-Federal funds to each $5 of the Federal grant or contract. There are authorized to be appropriated funds necessary for fiscal years 2010 through 2014.

The Secretary will make performance information summarizing data on quality measures available to the public through standardized Internet websites. The Secretary will consult with multi-stakeholder groups on the design and format of each website. There are authorized to be appropriated funds necessary for fiscal years 2010 through 2014.

**Part III - Encouraging Development of New Patient Care Models**

**Section 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS**

The Secretary will establish a Center for Medicare and Medicaid Innovation (CMI) within CMS to test innovative payment and service delivery models to reduce program expenditures while improve the coordination, quality, and efficiency of health care services provided to Medicare and Medicaid beneficiaries. By January 1, 2011, the CMI will be operational.

The CMI will test payment and service delivery models as selected by the Secretary that *may include*:

- Promoting broad payment and practice reform in primary care;
- Contracting directly with groups of providers to promote innovative care delivery models;
- Promote care coordination between providers that transition away from fee-for-service based reimbursement toward salary-based payment;
- Supporting care coordination for chronically ill individuals use health information technologies;
- Establishing community-based health teams to support small-practice medical homes with chronic care management; and
- Allowing States to test and evaluate systems of all-payer payment reform.

A complete list of potential models can be found in 3021 (b)(2)(B)i-xviii of this Act.

When selecting models for testing the CMI will consider if the model:

- Includes a regular process for monitoring and updating patient care plans;
- Places the applicable individual at the center of the care team;
- Provides for in-person contact;
- Uses technology to coordinate care over time and across settings;
- Provides for maintenance of a close relationship between various providers;
- Relies on a team-based approach to interventions; and
- Enables sharing of information between providers, patients, and caregivers.

Budget models must be budget neutral. The model may remain in place if, upon evaluation, it improves the quality of care without increasing spending; reduces spending without reducing the quality of care; or improves the quality of care while reducing spending. These evaluations will be made available to the

public. *The Secretary may expand the duration and scope of a model*. The Center may test models in CHIP.

There are appropriated $5 million for design, implementation and evaluation in fiscal year 2010. For fiscal years 2011 through 2019, $10 billion are appropriated and at least $25 million must be made available each year. Beginning in 2012, the Secretary will report on activities under this section to Congress annually.

*(This section is modified in section 10306)*

**Section 3022. Medicare Shared Savings Program**

By January 1, 2012, the Secretary will establish a shared savings program that promotes accountability and coordinates services under Medicare parts A and B and encourages investment in infrastructure. Under this program, groups of providers may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO). An ACO will:

- Be accountable for the quality, cost, and overall care of the Medicare beneficiaries assigned;
- Participate in the program for at least 3 years;
- Have a formal legal structure;
- Have sufficient primary care professionals for the number of beneficiaries assigned (at least 5,000 beneficiaries);
- Provide information regarding participating professionals;
- Define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care; and
- Demonstrate that it meets patient-centeredness criteria.

An ACO must meet quality standards determined by the Secretary, including measures of clinical processes and outcomes, patient experience of care, and utilization. The Secretary will establish quality performance standards and specify higher standards and new measures to improve the quality of care provided by ACOs over time.

Under the program, providers and suppliers in an ACO will continue to receive payments under the original fee-for-service from Medicare. A participating ACO will receive an additional payment for shared savings if it meets quality standards and average per capita Medicare expenditures are below the applicable benchmark specified by the Secretary.

The Secretary will set benchmarks for each agreement period, adjusted for beneficiary characteristics and updated for growth in national per capita expenditures for Medicare parts A and B.

Payment to a participating ACOs meeting requirements will be a percent of the difference between the ACO's benchmark and the estimated average per Medicare expenditures in a year for the ACO.

**Section 3023. National Pilot Program on Payment Bundling**

By January 1, 2013, the Secretary will establish a pilot program for integrated care during an episode of care requiring hospitalization to improve the coordination, quality and efficiency of health care services provided under Medicare Part A or Part B.

The pilot program will be conducted for 5 years, and may be extended. Development of the program will include selecting patient assessment instruments and consulting with the Agency for Healthcare Research

and Quality (AHRQ) to develop quality measures. Bundled payments will be comprehensive, covering the costs of applicable services and other appropriate services provided to an individual during an episode of care. All services, including post-acute care, will be provided or directed by the entity participating in the pilot program.

Participating entities in the pilot program will submit to the Secretary, and to the extent applicable through electronic health records, data on the following quality measures:

- Functional status improvement;
- Reducing rates of avoidable hospital readmissions;
- Rates of discharge to the community;
- Rates of admission to an emergency room after a hospitalization;
- Incidence of health care acquired infections;
- Efficiency measures;
- Measures of patient-centeredness of care; and
- Measures of patient perception of care.

The Secretary will consult with small rural hospitals regarding their participation in the pilot program. *By January 1, 2016, the Secretary will submit a plan for implementing an expansion of the pilot program if it would reduce spending and improve or not reduce the quality of patient care under this title.*

*(This section is modified in section 10308)*

**Section 3024. Independence at Home Demonstration Program**

The Secretary will conduct a demonstration program to test a payment incentive and service delivery model that uses home-based primary care teams to reduce expenditures and improve health outcomes for services provided under Medicare Parts A and B.

The demonstration will test if this model is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings to meet goals, including reducing hospitalizations and improving efficiency.

An independence at home medical practice is a legal entity:

- Comprised of an individual physician or nurse practitioner or group of such providers;
- Organized at least in part to provide physicians' services;
- Has documented experience providing home-based primary care services to high-cost chronically ill beneficiaries;
- Provides services to at least 200 applicable beneficiaries; and
- Uses electronic health information systems.

The entity will report to the Secretary on quality measures and provide appropriate data for monitoring and evaluating the demonstration program.

An estimated annual spending target will be assigned for each qualifying entity on a per capita basis. If actual expenditures are estimated to be 5 percent less than the spending target, then the entity will receive a portion of the savings as an incentive payment. An entity may be terminated from the demonstration if no incentive payments are earned for 2 consecutive years or quality standards are not met.

The demonstration program will begin by January 1, 2012 and preference will be given to practices in high-cost areas of the country and with relevant experience and technology use. The number of applicable beneficiaries in the demonstration program will not exceed 10,000.

The Secretary will conduct an evaluation of the demonstration program and submit a report to Congress. A total of $5 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund for each of fiscal years 2010 through 2015 to administer and carry out the demonstration program.

**Section 3025. Hospital Readmissions Reduction Program**

In fiscal years beginning after October 1, 2012, payments to applicable hospitals will be adjusted based on readmissions. *Payments for discharges from an applicable hospital will be reduced by the product of the base operating DRG and the adjustment factor*. The adjustment factor is equal to the greater of:

- 1 – (Aggregate payments for excess readmission ÷ Aggregate payments for all discharges); or
- The floor adjustment factor (0.99 on fiscal year 2013, 0.98 in fiscal year 2014, or 0.97 in fiscal year 2015 and subsequent years).

The Secretary will make public readmission rates under the program and ensure applicable hospitals have an opportunity to review and submit corrected information. The Secretary will make information on all patient readmission rates available on the CMS Hospital Compare website.

*(This section is modified in section 10309)*

**Section 3026. Community-Based Care Transitions Program**

The Secretary will establish a Community-Based Care Transitions Program to fund entities that provide improved care transition services to high-risk Medicare beneficiaries. An eligible entity is a hospital with a high readmission rate as defined in the Social Security Act or an appropriate community-based organization that provides transition services across a continuum of care.

The program will be conducted for a 5 year period beginning January 1, 2011 and may be expanded. An eligible entity must submit an application which includes at least 1 care transition intervention, and may be one of the following:

- Initiating care transition services at least a day before discharge;
- Arranging timely post-discharge follow-up services;
- Providing assistance to ensure productive and timely interactions between patients and providers;
- Assessing and actively engaging the beneficiary through self-management support; and
- Conducting comprehensive medication review and management.

This Act allocates a total of $500 million to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for fiscal years 2011 through 2015 for the program.

**Section 3027. Extension of Gainsharing Demonstration**

Gainsharing demonstration projects in operation as of October 1, 2008 are extended through September 20, 2011. These projects encourage collaboration between hospitals and physicians to improve the quality and efficiency of care provided to Medicare beneficiaries. Hospitals provide remuneration to physicians that represent a share of cost savings from their collaboration. An additional $1.6 million is allocated for

fiscal year 2010 that may be used through 2014 or until expended. The final report on the demonstration program is due by March 31, 2013.

## Subtitle B - Improving Medicare for Patients and Providers

### Part I - Ensuring Beneficiary Access to Physician Care and Other Services

**Section 3101. Increase in the Physician Payment Update**

*(This section is repealed in section 10310)*

**Section 3102. Extension of the Work Geographic Index Floor and Revisions to the Practice Expense Geographic Adjustment under the Medicare Physician Fee Schedule**

The Work Geographic Index is extended through 2010. Services, employee wages and rent portions of the practice expense geographic index will reflect:

- *1/2 × (Relative cost of employee wages and rent – National average of such wages and rent) provided in 2010 and subsequent years.*

The Secretary will analyze current methods of establishing practice expense geographic adjustments and evaluative data on the costs of operating a medical practice in different fee schedule areas. This information will be used to make appropriate adjustments by January 1, 2012.

*(This section is modified in section 1108 of the Reconciliation Act)*

**Sections 3103, 3104, 3105, 3106, and 3107. Extension of Certain Programs**

The following programs will be extended through 2010:

- Process of allowing exceptions to limitations on medically necessary therapy;
- Reimbursement to qualified rural hospitals for certain clinical laboratory services;
- Bonus payments made by Medicare for ground and air ambulance services in rural and other areas;
- *Certain payment rules for long-term care hospital services and a moratorium on the establishment of certain hospitals and facilities*; and
- Physician fee schedule payment rate for psychiatric services.

*(This section is modified in section 10312)*

**Section 3108. Permitting Physicians Assistants to Order Post-Hospital Extended Care Services**

Beginning January 1, 2011, physician assistants can order post-hospital skilled nursing care in Medicare programs.

**Section 3109. Exemption of Certain Pharmacies for Accreditation Requirements**

A pharmacy will not have to submit evidence of accreditation to the Secretary before January 1, 2011. The Secretary may apply alternative accreditation standards to exempt pharmacies. After January 1, 2011, pharmacies who receive less than 5 percent of total pharmacy sales from Medicare billings for the 3

previous years are exempt from accreditation, as long as the pharmacy submits notice that it qualifies for the exemption and agrees to submit materials as part of an audit on random samples.

**Section 3110. Part B Special Enrollment Period for Disabled TRICARE Beneficiaries**

There will be a 12-month special enrollment period for any individual who is a covered beneficiary of TRICARE who is eligible for Medicare due to a disability or end stage renal failure. The Secretary of Defense will collaborate with the Secretary of Health and Human Services to identify eligible individuals and notify them of this special enrollment. This is effective with respect to initial enrollment periods that end after the date of the enactment of this Act.

**Section 3111. Payment for Bone Density Tests**

Payment for dual x-ray absorptiometry services performed in 2010 and 2011 will be:

- 70 percent × (Relative value for service for 2006 × Conversion factor for 2006 × Geographic adjustment factor).

The Institute of Medicine of the National Academies will conduct a study on the effects of Medicare payment reductions for dual x-ray absorptiometry on access to the service in 2007, 2008, and 2009.

**Section 3112. Revision to the Medicare Improvement Fund**

$22.29 billion in the Medicare Improvement Fund will be removed.

**Section 3113. Treatment of Certain Complex Diagnostic Laboratory Tests**

The Secretary will conduct a demonstration project under Medicare Part B where separate payments are made for complex diagnostic laboratory tests (gene protein analysis, topographic genotyping, or a cancer chemotherapy sensitivity assay), with appropriate payment rates for such tests. The demonstration project will run for the 2 year period beginning July 1, 2011. Payments will be made from the Federal Supplemental Medical Insurance Trust Fund and may not exceed $100 million.

The Secretary will submit a report to Congress within 2 years of the completion of the demonstration project. A total of $5 million will be available for administering this section by transferring funds from the Federal Supplemental Medical Insurance Trust Fund.

**Section 3114. Improved Access for Certified Nurse-Midwife Services**

The payment to certified nurse midwives will be increased to the full rate that would be paid to a physician for the same covered services provided after January 1, 2011.

**Part II - Rural Protections**

**Sections 3121, 3122, 3123, 3124 and 3125. Extension of Certain Programs**

The following rural Medicare protection programs will be extended:

- The outpatient hold harmless provisions for hospitals in a rural area are extended through 2010, and all sole community hospitals are eligible for hold harmless provisions through January 1, 2011;
- The reasonable costs payment for laboratory services provided by small rural hospitals will be extended for the 1 year period beginning July 1, 2010;

- The rural community hospital demonstration program will be extended for *1 additional year* and will be expanded to 20 States and no more than 30 rural community hospitals during the extension period;
- The Medicare-dependent hospital program will be extended through October 1, 2012; and
- Medicare inpatient hospital payment adjustments for low-volume hospitals will be extended with a sliding scale for discharges occurring in fiscal years 2011 and 2012.

*(This section is modified in section 10313)*

**Section 3126. Improvements to the Demonstration Project on Community Health Integration Models in Certain Rural Counties**

Changes are made to remove the limit on the number of eligible counties for the demonstration project and replacing rural health clinic services with physicians' services in the definitions section relevant to the demonstration project.

**Section 3127. Med PAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas**

The Medicare Payment Advisory Committee will conduct a study on the adequacy of Medicare payments to providers and suppliers in rural communities and report findings to Congress by January 1, 2011. The report will include recommendations and an analysis of adjustments in payments, access by Medicare beneficiaries to services, adequacy of payments, and quality of care in rural areas.

**Section 3128. Technical Correction Related to Critical Access Hospital Services**

Critical access hospitals are eligible to receive 101 percent of reasonable cost for outpatient care and ambulance service.

**Section 3129. Extension of and Revisions to Medicare Rural Hospital Flexibility Program**

The Medicare Rural Hospital Flexibility Program will be extended through 2012. The program will allow grant made after January 1, 2010 to be used by eligible rural hospitals to participate in delivery system reforms stipulated in this Act, such as value-based purchasing programs and the pilot program on payment bundling.

## Part III - Improving Payment Accuracy

**Section 3131. Payment Adjustments for Home Health Care**

For *2013* and subsequent years, the Secretary will adjust the amount that would otherwise be paid for home health care services by a percentage that will consider the number of visits, average cost, and mix and intensity of services in an episode. The adjustments will be phased in over a 4-year period and the amount of any adjustment for the year may not exceed 3.5 percent of the applicable amount. The Medicare Payment Advisory Commission will conduct a study on the impact of these adjustments and submit a report with recommendations to Congress by January 1, 2015.

Adjustments are made to payments for outliers because of unusual variations in the type or amount of medically necessary care. There will be a 10 percent cap on the estimated total amount of payments made under this section.

An increase in payments for home health services in rural areas is extended for episodes and visits from April 1, 2010 through January 1, 2016. *The Secretary will conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies and treating Medicare beneficiaries with varying severity levels of illness, with a report submitted to Congress by March 1, 2011.*

*(This section is modified in section 10315)*

**Section 3132. Hospice Reform**

The Secretary will collect additional data and information to revise payments for hospice care by January 1, 2011, including:

- Charges and payments;
- Number of days of hospice care attributable to individuals eligible or enrolled in Medicare Part A;
- Number of days of hospice care, cost of service, and amount of payment with respect of each type of service included in hospice care;
- Number of hospice visits;
- Type of practitioner providing the visit; and
- Length of the visit.

Revisions will be made to the Medicare methodology for determining the payment rates for services involved in hospice care based on this data by October 1, 2013. The aggregate expenditures of the revised payment rates will not exceed what would have been spent the fiscal year with no revisions.

**Section 3133. Improvement to Medicare Disproportionate Share Hospital (DSH) Payments**

For fiscal year 2014 and subsequent years, the amount of DSH payments will be 25 percent of the amount that would otherwise be made. An additional amount will be paid to such hospitals based on one of the following factors:

- Factor one: Aggregate amount of payments with no revision – Aggregate amount out payments made;
- *Factor two: 1 – [(Percent uninsured in 2012 – Percent uninsured based on most recent data) ÷ 100]*;
  - For fiscal years 2014-2017, the percentage is of uninsured individuals under age 65; and
  - For fiscal years 2018 and subsequent years, the percentage is of uninsured individuals.
- Factor three: Amount of uncompensated care at hospital ÷ Aggregate amount of uncompensated care for all applicable hospitals.

*(This section is modified in section 10316)*
*(This section is further modified in section 1104 of the Reconciliation Act)*

**Section 3134. Misvalued Codes under the Physician Fee Schedule**

The Secretary will periodically identify, review, and make appropriate adjustments to misvalued services under the physician fee schedule. The Secretary will examine codes:

- With the fastest growth;
- That have experienced substantial changes in practice expenses;
- For new technologies or services;
- With low relative values; and

- Which have not been subject to review since the implementation of the RBRVS.

The Secretary may use existing processes, conduct surveys, or use contractors to do this. The Secretary will establish a process to validate relative value units under the fee schedule.

**Section 3135. Modification of Equipment Utilization Factor for Advancing Imaging Services**

Diagnostic imaging service payments will be changed. By January 1, 2013, the Chief Actuary of CMS will make publicly available an analysis of whether the savings under this section are projected to exceed $3 billion for the period 2010 through 2019.

*(This section is modified in section 1107 of the Reconciliation Act)*

**Section 3136. Revision of Payment for Power-Driven Wheelchairs**

Lump sum Medicare payments for power-driven wheelchairs will be prohibited at the time the wheelchair is supplied.

**Section 3137. Hospital Wage Index Improvement**

The Tax Relief and Health Care Act will be extended through September 30, 2010.

By December 31, 2011, the Secretary will submit a plan to reform the hospital wage index system that:

- Takes into account the *Report to Congress: Promoting Greater Efficiency in Medicare*;
- Uses Bureau of Labor Statistics data;
- Minimizes wage index adjustments between and within metropolitan statistic areas and statewide rural areas;
- Includes methods to minimize the volatility of wage index adjustments;
- Takes into account the effect implantation would have on providers and each region of the country;
- Addresses issues related to occupational mix; and
- Provides a transition.

**Section 3138. Treatment of Certain Cancer Hospitals**

The Secretary will study whether cancer hospitals exempt from the outpatient prospective payment system have higher costs than other hospitals and make appropriate adjustments that reflect that analysis.

**Section 3139. Payment for Biosimilar Biological Products**

Beginning in 2010, the add-on payment rate for biosimilar biological products reimbursement under Medicare Part B will be 6 percent of the average sales price of the brand biological product.

**Section 3140. Medicare Hospice Concurrent Care Demonstration Program**

A 3-year Hospice Concurrent Care Demonstration Program will be established to allow beneficiaries to receive hospice care and all other Medicare covered services at the same time. The Secretary will conduct an independent evaluation of the demonstration program on improving patient care, quality of life, and cost-effectiveness, with a report to be submitted to Congress.

**Section 3141. Application of Budget Neutrality on a National Basis in the Calculation of the Medicare Hospital Wage Index Floor**

Starting October 1, 2010, the national hospital wage index floor will be budget neutral through a uniform, national adjustment to the area wage index.

**Section 3142. HHS Study on Urban Medicare-Dependent Hospitals**

The Secretary will conduct a study on the need for an additional payment to urban Medicare-dependent hospitals for inpatient services. The study will include an analysis of the Medicare inpatient margins of urban Medicare-dependent hospitals as compared to other hospitals and whether payments to Medicare-dependent, small rural hospitals should be applied to urban Medicare-dependent hospitals.

**Section 3143. Protecting Home Health Benefits**

Any changes made in this Act will not reduce guaranteed home health benefits under Medicare.

## Subtitle C - Provisions Relating to Part C

**Section 3201. Medicare Advantage Payment**

*(This section is repealed in section 1102 of the Reconciliation Act)*

**Section 3202. Benefit Protection and Simplification**

The cost-sharing for the following services in Medicare Advantage plans cannot be greater than the cost-sharing under traditional fee-for-service in Medicare Parts A and B:

- Chemotherapy;
- Renal dialysis;
- Skilled nursing care; and
- Others that the Secretary identifies.

The changes will be applied to plans beginning January 1, 2011.

Rebates to Medicare Advantage plans will be prioritized accordingly: first by reducing cost-sharing for beneficiaries and second by providing preventive and wellness health benefits.

*(This section is modified in section 1102 of the Reconciliation Act)*

**Section 3203. Application of Coding Intensity Adjustment during Medicare Advantage Payment Transition**

*(This section is repealed in section 1102 of the Reconciliation Act)*

**Section 3204. Simplification of Annual Beneficiary Election Periods**

Beginning in 2011, Medicare Advantage enrollees may change their coverage to traditional Medicare during the first 45 days of a year.

**Section 3205. Extension for Specialized MA Plans for Special Needs Individuals**

Special Needs Plans (SNP) program, which provides Medicare Advantage coverage for individuals with special needs, will be extended through 2013. SNPs must be certified by the National Committee for Quality Assurance.

Payments for SNPs may be adjusted according to the payment rules for programs of all-inclusive care for the elderly.

A transition process to traditional Medicare or a Medicare Advantage plan will be established for people currently enrolled in SNPs that no longer meet the enrollment definitions.

For 2011 and subsequent years, a risk score will be established that reflects the risk profile and chronic health status for new enrollees of Medicare Advantage plans with special needs.

**Section 3206. Extension of Reasonable Cost Contracts**

Reasonable cost contracts may be extended through January 1, 2013.

**Section 3207. Technical Correction to MA Private Fee-For-Service Plans**

The Secretary has the ability to waive requirements that hinder the offering of coordinated care plans to employers who currently contract Medicare Advantage fee-for-services plans.

**Section 3208. Making Senior Housing Facility Demonstration Permanent**

Senior housing facility plans that were operated under a demonstration project may be operated by a Medicare Advantage plan.

**Section 3209. Authority to Deny Plan Bids**

Beginning in 2011, the Secretary is not required to accept every bid submitted by a Medicare Advantage organization or prescription drug plan sponsor, particularly if they propose significant increases in cost-sharing or decreases in benefits.

**Section 3210. Development of New Standards for Certain Medigap Plans**

The Secretary will request the National Association of Insurance Commissioners review to revise the standards for benefit packages in Medigap plans to encourage the use of appropriate physicians' services under Medicare part B. Medigap plans or Medicare supplemental plans are health insurance sold by private insurance companies to cover benefits not included in the original Medicare plan.

## Subtitle D - Medicare Part D Improvements for Prescription Drug Plan and MA-PD

**Section 3301. Medicare Coverage Gap Discount Program**

Drug manufacturers are required to offer a 50 percent discount on brand name medications to Medicare Part D beneficiaries in the coverage gap, beginning July 1, 2010. The discounted price will be applied at the point-of-sale of an applicable drug.

Supplemental benefits for applicable drugs under a prescription drug plan or Medicare Advantage-Prescription Drug plan must be applied before a beneficiary can receive the discount. Each manufacturer with an agreement under this section is subject to an audit. The Secretary has authority to impose a civil money penalty on a manufacturer that does not provide discounts.

**Section 3302. Improvement in Determination of Medicare Part D Low-Income Benchmark Premium**

Low-income beneficiaries who are eligible for both Medicare and Medicaid are given subsidies for Medicare part D. Beginning January 1, 2011, Medicare Advantage rebates or bonus payments will not be included in determining the low-income benchmark premium.

**Section 3303. Voluntary de Minimus Policy for Subsidy Eligible Individuals under Prescription Drug Plans and MA-PD Plans**

A prescription drug plan that bids a minimal amount above the low-income subsidy benchmark may absorb the cost of this difference and waive the premium for subsidy eligible individuals. Effective January 1, 2011.

**Section 3304. Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance**

Beginning January 1, 2011, the surviving spouse of a low-income subsidy couple is allowed to delay redetermination of low-income subsidy eligibility for 1 year.

**Section 3305. Improved Information for Subsidy Eligible Individuals Reassigned to Prescription Drug Plans and MA-PD Plans**

Beginning in 2011, if a subsidy eligible individual enrolled in a prescription drug plan is reassigned to another plan, they must be informed within 30 days of the formulary differences between the plans.

**Section 3306. Funding Outreach and Assistance for Low-Income Programs**

This Act allocates $45 million for fiscal years 2010 through 2012 to the CMS Program Management Account, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach Enrollment. The Secretary may ask an entity receiving a grant under this section to support outreach activities aimed at preventing disease and promoting wellness.

**Section 3307. Improving Formulary Requirements for Prescription Drug Plans and MA-PD Plans with Respect to Certain Categories or Classes of Drugs**

Any organization offering a prescription drug plan must identify all covered Medicare Part D drugs in the categories and classes identified by the Secretary. Until additional regulations are established the following categories and classes will be used: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection.

Amendments in this section will apply to plan year 2011 and subsequent years.

**Section 3308. Reducing Part D Premium Subsidy for High-Income Individuals**

There will be a reduction in premium subsidies for Medicare Part D beneficiaries whose adjusted gross income exceeds the Medicare Part B income threshold. The Commissioner of Social Security will make any determination needed to carry out the income-related increase in the base beneficiary premium, based on information provided by the Secretary. The monthly adjustment amount will be collected by withholding from Social Security benefit payments for these individuals.

**Section 3309. Elimination of Cost-Sharing for Certain Dual Eligible Individuals**

Cost-sharing is eliminated for dual eligible Medicare Part D beneficiaries receiving care under a home and community-based waiver program who would otherwise require institutional care. This change will be implemented no later than January 1, 2012.

**Section 3310. Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities Under Prescription Drug Plans and MA-PD Plans**

Prescription drug plans will be required to use specific, uniform dispensing techniques developed in consultation with stakeholders for Medicare Part D beneficiaries residing in long-term care facilities by January 1, 2012.

**Section 3311. Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System**

The Secretary will develop and maintain a complaint system to collect information about prescription drug plan complaints. An electronic complaint form will be available at the www.medicare.gov website, and the Secretary will submit an annual report on the system.

**Section 3312. Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA-PD Plans**

Prescription drug plan sponsors will use a single, uniform exceptions and appeals process, and provide enrollees access to the process through a toll-free phone number and a website by January 1, 2012.

**Section 3313. Office of the Inspector General Studies and Reports**

The Inspector General of HHS will conduct a study on the extent to which formularies used by prescription drug plans include drugs commonly used by dual eligible beneficiaries.

The Inspector General of HHS will also conduct a study on prices of covered drugs under Medicare Part D and Medicaid, including an assessment of the financial impact of any price discrepancies on the Federal Government or on enrollees. By October 1, 2011, the Inspector General will submit a report to Congress which cannot include information that is deemed proprietary or is likely to negatively affect the ability to negotiate prices for covered drugs.

**Section 3314. Including Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service in Providing Prescription Drugs toward the Annual Out-of-Pocket Threshold under Part D**

Costs incurred for drugs by the AIDS Drug Assistance Program or Indian Health Services will count towards the beneficiaries' annual out-of-pocket threshold effective January 1, 2011.

**Section 3315. Immediate Reduction in Coverage Gap in 2010**

*(This section is repealed in section 1101 of the Reconciliation Act)*

## Subtitle E - Ensuring Medicare Sustainability

**Section 3401. Revision of Certain Market Basket Updates and Incorporation of Productivity Improvements Into Market Basket Updates that Do Not Already Incorporate Such Improvements**

*A productivity adjustment will be incorporated into the market basket update for inpatient hospitals beginning in 2010, skilled nursing facilities beginning in 2012, long-term care hospitals beginning in 2010, inpatient rehabilitation facilities beginning in 2012, home health agencies beginning in 2011, psychiatric hospitals beginning in 2010, hospice care beginning in 2013, and outpatient hospital services beginning in 2012.*

Market basket reductions will also be implemented for various services including: dialysis, ambulance, ambulatory surgical centers, laboratory, durable medical equipment, and prosthetics and orthotics. Additionally, fee schedules for certain services under Medicare Part B will be updated and include a productivity adjustment. Amendments in this section will not apply to discharges before April 1, 2010.

*(This section is modified in section 10319 and 10322)*

**Section 3402. Temporary Adjustment to the Calculation of Part B Premiums**

The income threshold for Medicare Part B premiums will remain at 2010 levels through 2019. Those who exceed the income threshold will pay a higher premium for Part B.

**Section 3403. Independent Medicare Advisory Board**

An Independent Medicare Advisory Board consisting of 15 experts appointed by the President will be created to reduce the per capita rate of growth in Medicare spending. Each year the Chief Actuary of CMS will determine a projected rate of growth for Medicare spending. If the projected rate exceeds the target rate for that year, the Board will write a proposal with recommendations to reduce the Medicare per capita growth rate.

These recommendations will be implemented unless Congress passes an alternative provision that achieves the same level of savings. None of the recommendations can ration health care, raise premiums, or increase cost-sharing. *As feasible, the Board will*:

- Give priority of recommendations that extend Medicare solvency;
- Include recommendations that improve the health care delivery system and health outcomes;
- Include recommendations that protect and improve beneficiaries access to services;
- Consider the effects of changes in payments to providers on beneficiaries; and
- Consider the unique needs of Medicare beneficiaries who are dual eligible.

The Board may not submit a proposal before January 15, 2014, and will submit a draft of each proposal to the Medicare Payment Advisory Committee (MedPAC) and the Secretary for review. Congress may consider alternate provisions on a fast-track basis. The Board may be disbanded by a joint resolution in 2017. A Consumer Advisory Council will be established to advise the Board on the impact of payment policies on consumers. It will consist of 10 consumer representatives from different regions.

For fiscal year 2012, $15 million is appropriated for the Board to carry out its duties and functions. In subsequent years, this amount increased by the annual percentage increase in the consumer price index will be appropriated. The Comptroller General will conduct a study and analysis on changes that result from the recommendations of the Board.

*(This section is modified in section 10320)*

## Subtitle F - Health Care Quality Improvements

### Section 3501. Health Care Delivery System Research; Quality Improvement Technical Assistance

The Center for Quality Improvement and Patient Safety of AHRQ will support through contracts or grants health care delivery system improvement and the development of tools to ease adoption of best practices. Supported research will:

- Address priorities identified in the national strategic plan;
- Identify areas lacking evidence;
- Address concerns of health care institutions and providers;
- Reduce preventable morbidity and mortality by building capacity for patient safety research;
- Support the discovery of processes for reliable, safe, and efficient delivery of health care;
- Communicate research findings and translate evidence into practice recommendations;
- Expand demonstration projects for improving the quality of children's health care and the use of health information technology;
- Identify and mitigate hazards;
- Include systemic reviews of existing practices; and
- Include methods for measuring and evaluating progress.

The research findings of the Center will be available to the public in multiple media and formats to meet the needs of health care providers and consumers. A total of $20 million is appropriated to carry out these activities for fiscal years 2010 through 2014.

The Center will award technical assistance and implementation grants or contracts for eligible entities to assist health care institutions and providers to adapt and implement models and practices identified in research by the Center. Eligible entities will have demonstrated expertise in providing information and technical support to health care providers regarding quality improvement and have non-Federal matching funds for any grant or contract under this section.

### Section 3502. Establishing Community Health Team to Support the Patient-Centered Medical Home

A program will be established by the Secretary to provide grants or contracts with eligible entities to establish community-based, interdisciplinary teams to support primary care practices, with particular focus on patient-centered medical homes. Eligible entities must be a State or Indian tribe or tribal organization that submits an application with a plan for achieving long-term financial sustainability and incorporates prevention, patient education, and care management in health care delivery. Entities receiving a grant under this section must submit a report evaluating their activities.

**Section 3503. Medication Management Services in Treatment of Chronic Disease**

The Secretary will establish a program to award grants or contracts to eligible entities to implement medication management (MTM) services to treat targeted individuals with chronic diseases. MTM services will include:

- Performing or obtaining necessary assessments of each patient;
- Formulating a medication treatment plan;
- Selecting, initiating, modifying, or administering medication therapy;
- Monitoring and evaluating patient response to therapy;
- Performing a comprehensive medication review;
- Documenting delivered care and communicating essential information in a timely manner;
- Providing education and information to improve understanding and appropriate use of medications; and
- Coordinating and integrating MTM services within the broader health care management services provided to the patient.

The Secretary will submit a report to Congress on the effectiveness of MTM services.

**Section 3504. Design and Implementation of Regionalized Systems for Emergency Care**

The Assistant Secretary for Preparedness and Response is authorized to award at least 4 contracts or grants to eligible entities for pilot projects that design, implement, and evaluate models of regionalized, comprehensive, and accountable emergency care and trauma systems. An eligible entity is a state, partnership of states, Indian tribe, or partnership of Indian tribes.

Pilot projects must:

- Coordinate with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities;
- Include a mechanism to ensure a patient is taken to the medically appropriate facility in a timely manner;
- Allow for tracking and coordination of prehospital and hospital resources;
- Includes a consistent region-wide prehospital, hospital, and interfacility data management system.

States must provide $1 of non-Federal funds to match every $3 of Federal funds.

The Secretary will support research on emergency medicine, including models of service delivery, translation of research into improved practice, and pediatric emergency medicine.

**Section 3505. Trauma Care Centers and Service Availability**

Grants will be awarded to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers. The amount of grants for substantial uncompensated care costs will depend on the percentage of visits that are Medicaid, charity care or self-pay patients.

Preference will be given to trauma centers in areas where access to emergency services has significantly decreased. A grant may not exceed $2 million per fiscal year. The Secretary will report to Congress biennially on these grants.

The Secretary will provide funding to States in order for them to award grants to eligible entities which carry out 1 or more of the following:

- Provide trauma centers funding in shortage areas;
- Provide for individual safety net trauma center fiscal stability;
- Reduce trauma center overcrowding;
- Establish new trauma centers in underserved areas;
- Enhance collaboration between trauma centers, other hospitals, and emergency medical services;
- Make capital improvements to enhance access and expedite trauma care;
- Enhance trauma surge capacities;
- Ensure expedient receipt of trauma care patients to the appropriate trauma center; and
- Enhance interstate trauma center collaboration.

Funds must not be used to supplant State funding. There are $100 million authorized for each of fiscal years 2010 through 2015.

**Section 3506. Program to Facilitate Shared Decision Making**

A program will be established to award grants or contracts that develop, test, and disseminate education tools that help patients and caregivers understand and communicate their preferences and values regarding treatment options.

Grants will be provided for the development of Shared Decisionmaking Resource Centers to provide technical assistance and disseminate best practices. Grants will also be provided to health care providers for the development and implementation of shared decisionmaking techniques. There are authorized such sums as may be necessary for fiscal year 2010 and subsequent years.

**Section 3507. Presentation of Prescription Drug Benefit and Risk Information**

The FDA will evaluate and determine if the use of drug fact boxes summarizing the benefits and risks of prescription drugs would improve health care decisionmaking by clinicians, patients, and consumers. A report will be submitted to Congress within a year of enactment of this Act, and if deemed beneficial, the Secretary will issue regulations within 3 years to implement this.

**Section 3508. Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals**

Grants will be issued to carry out demonstration projects that develop and implement academic curricula that integrate quality improvement and patient safety in the education of health professionals. The grantee must provide $1 of non-Federal funds for every $5 of Federal funds.

**Section 3509. Improving Women's Health**

An Office of Women's Health will be established in the DHSS. This office will:

- Establish short-range and long-term goals and coordinate with other offices on activities within DHSS on issues relevant to women's health;
- Provide expert advice and consultation to the Secretary;
- Monitor HHS activities regarding women's health and identify coordination needs;
- Establish a HHS Coordinating Committee on Women's Health;
- Establish a National Women's Health Information Center;
- Coordinate efforts to promote women's health programs and policies in the private sector; and
- Provide for the exchange of information.

An identical office will be established in other health-related Federal Departments.

**Section 3510. Patient Navigator Program**

Demonstration programs to provide patient navigator services are reauthorized through 2015. This program, which assists patients in overcoming barriers to health services, is amended to require minimum core proficiencies in order for an entity to be eligible for a grant. Funds are appropriated as necessary for each of fiscal years 2011 through 2015.

**Section 3511. Authorization of Appropriations**

There are authorized appropriations in such sums as necessary to carry out this subtitle.

### Subtitle G - Protecting and Improving Guaranteed Medicare Benefits

**Section 3601. Protecting and Improving Guaranteed Medicare Benefits**

Nothing in this Act will reduce guaranteed benefits under Medicare. Savings generated for Medicare under this Act will be used to extend the solvency of the Medicare trust funds, reduce premiums and cost-sharing for Medicare beneficiaries, and improve or expand guaranteed Medicare benefits.

**Section 3602. No Cuts in Guaranteed Benefits**

Nothing in this Act will reduce or eliminate any benefits guaranteed by law to participants in Medicare Advantage plans.

## Title IV - Prevention of Chronic Disease and Improving Public Health

### Subtitle A - Modernizing Disease Prevention and Public Health Systems

**Section 4001. National Prevention, Health Promotion, and Public Health Council**

The President will establish the National Prevention, Health Promotion, and Public Health Council within HHS. The Council will be chaired by the Surgeon General and consist of representatives of various Federal agencies that interact with health and safety policy. The Council will:

- Provide coordination among Federal departments and agencies;
- Develop a national strategy on prevention, health promotion, public health and integrative health care strategy;
- Provide recommendations to the President and Congress;
- Consider and propose evidence-based models, policies, and innovative approaches; and
- Submit annual reports to the President and Congress.

An Advisory Group of 25 non-Federal members, including health professionals, appointed by the President will advise the Council.

**Section 4002. Prevention and Public Health Fund**

A Prevention and Public Health Fund will be established to provide for expanded and sustained investment in prevention and public health programs by increasing funding for programs authorized by the Public Health Services Act. The following amounts have been appropriated: $500 million for 2010, $750 million for 2011, $1 billion for 2012, $1.25 billion for 2013, $1.5 billion for 2014, and $2 billion for 2015 and each subsequent fiscal year.

**Section 4003. Clinical and Community Preventive Services**

This section expands the efforts of and improves the coordination between two task forces focused on preventive interventions.

The Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services and develops recommendations for their use. The Task Force, based in AHRQ, will publish recommendations on best practices in the Guide to Clinical Preventive Services.

The Community Preventive Services Task Force, based in the Centers for Disease Control and Prevention (CDC), uses a public health perspective to review the evidence on the effectiveness of population-based preventive services and develops recommendations for their use. The Task Force will publish recommendations on best practices in the Guide to Community Preventive Services.

**Section 4004. Education and Outreach Campaign Regarding Preventive Benefits**

A national public-private partnership will be created for a prevention and health promotion outreach campaign to raise awareness of health improvement across the life span. The CDC will implement a national media campaign on health promotion and disease prevention. The campaign will include a website, information distribution through health care providers, and a web-based personalized prevention plan tool. A total of $500 million has been appropriated for this campaign.

Each State will design a public awareness campaign to educate Medicaid enrollees on preventive and obesity-related services available through Medicaid.

## Subtitle B - Increasing Access to Clinical Preventive Services

**Section 4101. School-Based Health Centers**

A grant program is created for the establishment of school-based health centers. Priority will be given to centers that serve a large population of children eligible for Medicaid or CHIP. Funds may only be used for facilities and equipment. For each fiscal year 2010 through 2013, $50 million is appropriated.

A grant program is established to support the operation of school-based health centers serving medically underserved children. Preference may be given to communities with demonstrated barriers to care and high numbers of children who are uninsured, underinsured, or enrolled in public programs. Each grantee must match an amount equal to 20 percent of the grant with non-Federal resources. Grant funds must not supplant other Federal or State funds.

**Section 4102. Oral Health Care Prevention Activities**

The CDC, subject to the availability of appropriations, will establish a 5-year national, public education campaign on oral health care prevention and education. The campaign will be launched within 2 years of the date of enactment of this section and will target activities towards specific populations including: children, pregnant women, and the elderly.

The CDC will award grants for demonstrations on the effectiveness of research-based dental caries disease management. Grants for school-based sealant programs will be expanded to all 50 states. The CDC will also enter into cooperative agreements to establish oral health program guidance, oral health data collection and interpretation, a multi-dimensional delivery system for oral health, and to implement programs to improve oral health.

Oral health care components will be added to the Pregnancy Risk Assessment Monitoring System, the National Health and Nutrition Examination Survey, and the Medical Expenditures Panel Survey.

**Section 4103. Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

Medicare benefits will include personalized prevention plan services, which consists of a health risk assessment and may also include:

- Establishment or updates to an individual's medical and family history;
- A list of current providers and suppliers involved in an individual’s medical care;
- Detection of any cognitive impairment;
- Establishment or updates to a screening schedule for the next 5 to 10 years; and
- Personalized health advice and appropriate referrals.

The Secretary will establish guidelines for health risk assessments within 1 year of enactment of this Act. Beneficiaries are eligible for an annual preventive physical exam with no cost-sharing for personalized prevention plan services. These amendments are effective January 1, 2011.

**Section 4104. Removal of Barriers to Preventive Services in Medicare**

No coinsurance or deductibles will be required for most preventive services under Medicare, including personalized prevention plan services. Medicare will waive coinsurance requirements for services recommended with a grade of A or B by the Preventive Services Task Force effective on services provided after January 1, 2011.

**Section 4105. Evidence-Based Coverage of Preventive Services in Medicare**

Effective beginning January 1, 2010, the Secretary may modify the coverage of any currently covered preventive service in the Medicare program based on recommendations by the Preventive Services Task Force.

**Section 4106. Improving Access to Preventive Services for Eligible Adults in Medicaid**

The Medicaid option to provide other diagnostic, screening, preventive, and rehabilitative services will be expanded to include the preventive services recommended with a grade of A or B by the Preventive Service Task Force and vaccines recommended for adults by the Advisory Committee on Immunization Practices.

If a State covers these services with no cost-sharing, the Federal Medical Assistance Percentage will be increased by 1 percentage point for these services. These amendments are effective January 1, 2013.

**Section 4107. Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid**

Medicaid coverage will be required to include coverage for counseling and pharmacotherapy for cessation of tobacco use by pregnant women. No cost-sharing will be permitted for these services. These amendments are effective October 1, 2010.

**Section 4108. Incentives for Prevention of Chronic Diseases in Medicaid**

The Secretary will award grants to States to carry out initiatives that provide incentives to Medicaid beneficiaries who participate in programs promoting healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid beneficiaries, may address co-morbidities, and must have demonstrated success in helping individuals:

- Cease using tobacco products;
- Control or reduce weight;
- Lower cholesterol;
- Lower blood pressure; or
- Prevent or manage diabetes.

A State must carry out initiatives for at least 3 years and conduct an outreach and education campaign to make providers and Medicaid beneficiaries aware of the programs. Independent evaluation and assessment of initiatives will be contracted by the Secretary and States receiving grants must submit reports on a semi-annual basis to the Secretary. A final report will be submitted to Congress by July 1, 2016. A total of $100 million has been appropriated to carry out this section for the 5-year period beginning January 1, 2011.

## Subtitle C - Creating Healthier Communities

**Section 4201. Community Transformation Grants**

The CDC is authorized to award grants to State and local governments and community-based organizations to implement evidence-based community preventive health activities.

An eligible entity will submit a community transformation plan to the Director of the CDC which includes policy, environmental, pragmatic, and infrastructure changes needed to promote healthy living and reduce disparities. Activities in the plan may focus on:

- Creating healthier school environments;
- Creating infrastructure to support active living and access to nutritious foods;
- Developing and promoting programs that target a variety of age levels;
- Assessing and implementing workplace wellness programming and incentives;
- Working to highlight healthy options at restaurants;
- Prioritizing strategies to reduce ethnic/racial disparities; and
- Addressing special populations needs.

A grantee must submit a report to the Director annually, participate in meetings to discuss best practices and lessons learned, and develop models to replicate successful programs and activities. The Director will provide training on effective strategies, technical assistance to establish community transformation plan, and framework for evaluating programs under this grant.

Funds may not be used to create video games. There are authorized such sums as may be necessary for fiscal years 2010 through 2014.

**Section 4202. Healthy Aging, Living Well; Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries**

The CDC will award grants to State or local health departments and Indian tribes to launch 5-year pilot programs that provide public health community interventions, screenings, and clinical referrals for individuals aged 55-64.

Public health interventions may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles. Ongoing health screenings will be provided to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes. Individuals found to have risk factors will be referred for follow-up services. The grantee must measure changes in the prevalence of chronic disease risk factors, and the Secretary will conduct an annual evaluation of the program based on this data.

The Secretary will conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting health lifestyles and chronic disease management for Medicare beneficiaries. The CMS will conduct a study of the impacts of existing community prevention and wellness programs on participating Medicare beneficiaries.

This Act transfers funds from the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund totaling $50 million for this subsection.

**Section 4203. Removing Barriers and Improving Access to Wellness for Individuals with Disabilities**

Within a year of enactment of this Act, the Architectural and Transportation Barriers Compliance Board will set minimum criteria to ensure that individuals with accessibility needs are able to independently enter and exit medical diagnostic equipment to the maximum extent possible.

**Section 4204. Immunizations**

The Secretary will have the authority to negotiate and enter into contracts with manufacturers for the purchase vaccines for adults. A State may purchase additional quantities of adult vaccines from manufacturers at the price negotiated by the Secretary.

The CDC will establish a demonstration program to award grants to States to improve immunization coverage of children, adolescents, and adults through the use of evidence-based interventions. Funds will be used to implement intervention recommendations from the Community Preventive Services Task Force.

A State will submit an evaluation to the Secretary on progress in improving immunization coverage rates, and the Secretary will submit a report to Congress on the effectiveness of the demonstration program. Funds will be appropriated as necessary for the years 2010 through 2014 to carry out this program.

The Comptroller General of the United States will do a study on Medicare beneficiaries' ability to access routinely recommended vaccines and submit a report to Congress by January 1, 2011. There are appropriated $1 million to carry out this subsection.

**Section 4205. Nutrition Labeling of Standard Menu Items at Chain Restaurants**

Restaurants or retail food establishments that are part of a chain with 20 or more locations doing business under the same name must disclose, in a clear and noticeable way, nutrient content (including the number of calories) and a brief statement on the suggested daily caloric intake for standard menu items on menus, menu boards (including drive-through menu boards), and in a written form available upon consumer request.

Vending machines operated by a person who owns 20 or more vending machines must also disclose the number of calories of food items in a clear and noticeable manner.

Restaurants, retail food establishments, and vending machine operators may voluntarily elect to follow these requirements by registering with the Secretary. Standards for the format and manner of nutrient content disclosure will be established by the Secretary within a year of enactment of this Act.

**Section 4206. Demonstration Project Concerning Individualized Wellness Plan**

A pilot program will be established to test the impact of providing at-risk populations using community health centers an individualized wellness plan to reduce risk factors for preventable conditions. The Secretary will enter into agreements with no more than 10 community health centers for this program. Individualized wellness plans may include: nutritional counseling, a physical activity plan, alcohol and smoking cessation services, stress management, and dietary supplements.

**Section 4207. Reasonable Break Time for Nursing Mothers**

Employers will provide a reasonable break time for an employee to express breast milk for her nursing child for up to 1 year after the child's birth. The employer must provide a place that is not a bathroom for this purpose, and the break time does not have to be compensated. An employer with less than 50 employees is exempt from this requirement if it imposes an undue hardship.

## Subtitle D - Support for Prevention and Public Health Innovation

**Section 4301. Research on Optimizing the Delivery of Public Health Services**

Funding will be provided through the CDC for research on public health services and systems that includes evidence-based practices relating to prevention, analyzes how to translate research to real world settings, and identifies effective strategies for community settings. This research will be coordinated with the Community Preventive Services Task Force.

**Section 4302. Understanding Health Disparities: Data Collection and Analysis**

Within 2 years of the enactment of this title, any federally conducted or supported health care or public health program, activity, or survey must collect, to the extent possible, demographic data that can be aggregated by State, locality, institution, and subpopulation using collection and measurement standards. The National Coordinator for Health Information Technology will develop national standards for data management and develop interoperability and security systems.

Data will be analyzed to identify and monitor trends in health disparities. Analyses will be available to relevant Federal agencies. Data will be available for additional research by other Federal agencies, non-governmental agencies, and the public. Any data collected under Medicaid and CHIP must meet these requirements.

**Section 4303. CDC and Employer-Based Wellness Programs**

The CDC will provide technical assistance to employers to help them measure and evaluate wellness programs. The CDC will conduct a national survey to assess employer-based health policies and programs within 2 years of enactment of this Act. A report with recommendations for implementing effective employer-based health policies and programs will be submitted to Congress. Nothing in this section will be used to mandate requirements for workplace wellness programs.

**Section 4304. Epidemiology-Laboratory Capacity Grants**

The CDC will establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State, local and tribal health departments to improve surveillance for and response to infectious diseases and other public health conditions. Funding will be used to:

- Strengthen epidemiological capacity for identification and monitoring;
- Enhance laboratory practice;
- Improve information systems; and
- Develop and implement prevention and control strategies.

This Act appropriates $190 million each of fiscal years 2010 through 2013.

**Section 4305. Advancing Research and Treatment for Pain Care Management**

The Secretary will enter an agreement with the Institute of Medicine of the National Academies to hold a Conference on Pain. The conference will:

- Evaluate the adequacy of assessment, diagnosis, treatment and management of pain;
- Identify barriers to access to appropriate pain care;
- Establish an agenda to reduce barriers and improve pain care research, education, and clinical care; and
- Submit a summary report to Congress by June 30, 2011.

The Pain Consortium at the National Institutes of Health (NIH) is authorized to expand research on pain causes and treatments. The Secretary will establish the Interagency Pain Research Coordinating Committee to coordinate efforts within Federal agencies related to pain research. A grant program will be established to provide education and training to health care professionals in pain care.

**Section 4306. Funding for Childhood Obesity Demonstration Project**

This Act appropriates $25 million for fiscal years 2010 through 2014 for the Childhood Obesity Demonstration Project.

### Subtitle E - Miscellaneous Provisions

**Section 4401. Sense of the Senate Concerning CBO Scoring**

*(This section is removed in section 10405)*

**Section 4402. Effectiveness of Federal Health and Wellness Initiatives**

The Secretary will evaluate whether existing Federal health and wellness initiatives are effective in achieving their stated goals and submit a report to Congress with an explanation of what has and has not worked.

# Title V - Health Care Workforce

### Subtitle A - Purpose and Definitions

**Section 5001. Purpose**

The purpose of this title is to improve access to and delivery of health care services for all individuals by gathering and assessing comprehensive data, increasing the supply of a qualified health care work force, enhancing health care workforce education and training, and providing support to the existing health care workforce.

**Section 5002. Definitions**

Allied Health Professional*:* is an individual who has graduated and received an allied health professions degree or certificate from an institution of higher education and is employed by a public health agency or in a setting where patients might require health care services.

Health Care Career Pathway*:* is a set of courses and services that is aligned with the needs to healthcare industries in the region or State, prepares a student for entry into the full range of postsecondary options, provides academic and career counseling, meets State academic standards, and leads to 2 or more credentials.

Registered Apprenticeship Program: is an industry skills training program at the postsecondary level that combines technical and theoretical training through structured on the job learning with related instruction.

Physician Assistant Education Program: is an educational program that qualifies individuals to provide primary care medical services with the supervision of a physician.

Area Health Education Center: is a public or nonprofit organization that identifies and implements strategies and activities to address health care workforce needs in its service area.

Frontier Health Professional Shortage Area: is an area with a population density less than 6 persons per square mile within the service area and with respect to the distance or time traveled for the population to access care is excessive.

## Subtitle B - Innovations in the Health Care Workforce

### Section 5101. National Health Care Workforce Commission

A 15 member National Health Care Workforce Commission will be established to:

- Serve as a resource for Congress, the President, and States;
- Communicate and coordinate various Federal Departments on related activities;
- Evaluate education and training activities to see if demand for health care workers is being met;
- Identify and recommend ways to address barriers to coordination at the Federal, State or local levels; and
- Encourage innovations to address population needs, changes in technology, and other environmental factors.

Members of the Commission will serve 3 year terms, have expertise in health care workforce issues, represent a range of perspectives, and be appointed by the Comptroller General. Specific duties include: disseminating information on promising retention practices and communicating information on policies and practices that affect recruitment, education, training, and retention of the health care workforce.

The Commission will submit an annual report to Congress and the Administration on the current and projected workforce supply and demand with recommendations concerning national health care workforce priorities, goals, and policies. The Commission will also annually submit a report with a review of, and recommendations on, at least one high priority area.

Specific topics to be reviewed include: current health care workforce supply and distribution, health care workforce education and training capacity, education loan and grant programs, implications of new and existing Federal policies that impact the health care workforce, and the health care workforce needs of special populations. The Commission will review, assess, and report to Congress on the State Health Care Workforce Development Grant program established under section 5102.

### Section 5102. State Health Care Workforce Development Grants

A competitive health care workforce development grant program will be established to enable State partnerships to plan and carry out comprehensive health care workforce development strategies at the State and local levels. The program will be administered by HRSA and carried out in consultation with the National Health Care Workforce Commission.

Planning grants up to $150,000 for 1 year will be awarded to:

- Analyze State labor market information;
- Identify current and projected high demand health care sectors;
- Describe academic and health care industry standards for education and various credentials;
- Describe State education and training policies, models, or practices for the health care sector;
- Identify Federal or State policies or rules for developing a comprehensive health care workforce development strategy, barriers, and a plan to overcome barriers; and
- Participate in evaluation and reporting activities.

Each grantee must provide an amount to match at least 15 percent of the grant.

Implementation grants will be awarded for a 2 year period to state partnerships that received planning grants. Each State partnership receiving a grant must match an amount equal to 25 percent of the grant

amount. Grantees must use at least 60 percent of funds for competitive grants to encourage regional partnerships to address workforce development needs.

There are appropriated $8 million for planning grants in 2010, $150 million for implementation grants in 2010, and such sums as may be necessary for subsequent fiscal years.

**Section 5103. Health Care Workforce Assessment**

This section amends the Public Health Service Act to establish the National Center for Health Workforce Analysis to carry out activities previously done solely through grants and contracts. The National Center will work in coordination with the National Health Care Workforce Commission to:

- Analyze the health care workforce and workforce related issues;
- Collect, compile, and analyze data on health professions personnel;
- Annually evaluate workforce programs under this title;
- Develop and publish performance measures and benchmarks for programs under this title; and
- Establish, maintain, and publicize a national Internet registry of grants awarded under this title and a database to collect data from longitudinal evaluations on performance measures.

Grants or contracts will be awarded to eligible entities to collect, analyze, and report data to the National Center and to provide technical assistance to local and regional entities. Increased grant amounts will be available to conduct longitudinal evaluations of individuals who have received education, training, or financial assistance from a program under this title. There are appropriated for each fiscal year 2010 through 2014 $7.5 million for the National Center, $4.5 million for state and regional grants, and such sums as necessary for longitudinal evaluation grants.

## Subtitle C - Increasing the Supply of the Health Care Workforce

**Section 5201. Federally Supported Student Loan Funds**

This section amends the Public Health Service Act so if a student is noncompliant the interest rate on loans under this section will be 2 percent higher than if the student was compliant. The Secretary will not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act.

**Section 5202. Nursing Student Loan Program**

Loan amounts designated in section 836 of the Public Health Service Act will be increased and then adjusted based on future increases in the cost of attending nursing school.

**Section 5203. Health Care Workforce Loan Repayment Programs**

The Public Health Service act is amended to establish a pediatric specialty loan repayment program for individuals who commit to providing pediatric medial subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care for a specific period of time. There are appropriated $30 million for pediatric medical and surgical specialists for each fiscal year 2010 through 2014 and $20 million for child and adolescent mental and behavioral health professionals for each fiscal year 2010 through 2013.

**Section 5204. Public Health Workforce Recruitment and Retention Programs**

The Public Health Service act is amended to establish the Public Health Workforce Loan repayment program to repay education loans for public health professionals who commit to work in a Federal, State, local, or tribal public health agency for at least 3 years. There are appropriated $195 million for fiscal year 2010 and such sums as may be necessary for 2011 through 2015.

**Section 5205. Allied Health Workforce Recruitment and Retention Programs**

An Allied health Loan Forgiveness Program will be established to repay loans for allied health professionals working in public health agencies, acute care facilities, ambulatory care facilities, personal residences, and other settings with health professional shortages or in medically underserved areas.

**Section 5206. Grants for State and Local Programs**

Scholarships will be awarded to mid-career professionals in the public health and allied health professionals to enroll in a degree or professional training program to get additional training in their field. There are appropriated $60 million for 2010 and such sums as necessary for fiscal years 2011 through 2015, with funding split evenly between public health and allied health mid-career professionals.

**Section 5207. Funding for National Health Service Corps**

Appropriations for the National Health Service Corps are authorized for fiscal years 2010 through 2015 as follows:

- $320 million for fiscal year 2010;
- $414 million for fiscal year 2011;
- $535 million for fiscal year 2012;
- $691 million for fiscal year 2013;
- $893 million for fiscal year 2014; and
- $1.5 trillion for fiscal year 2015.

For 2016 and subsequent years, funding will be adjusted based on the costs of health professional education and the number of individuals residing in health professions shortage areas.

**Section 5208. Nurse-Management Health Clinics**

The Secretary will award grants to operate nurse-managed health clinics that provide primary care or wellness services to underserved or vulnerable populations. There are appropriated $50 million for fiscal year 2010 and such sums as may be necessary for fiscal years 2011 through 2014 to carry out this section.

**Section 5209. Elimination of Cap on Commissioned Corps**

The cap on the number of commissioned Corps members is eliminated.

**Section 5210. Establishing a Ready Reserve Corps**

This section amends the Public Health Service Act regarding the Ready Reserve Corps established for service in time of national emergency. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere. There are appropriated

for each fiscal year 2010 through 2014 $5 million for recruitment and training and $12.5 million for the Ready Reserve Corps.

## Subtitle D - Enhancing Health Care Workforce Education and Training

### Section 5301. Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship

The Secretary may make 5 years grants to or contracts with an eligible entity to:

- Develop and operate an accredited professional training programs in family medicine, general internal medicine or general pediatrics;
- Provide need-based financial assistance for participants of such programs;
- Develop and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine or general pediatrics;
- Develop and operate a program for training physicians teaching in community-based settings;
- Provide need-based financial assistance to physicians planning to teach in family medicine, general internal medicine or general pediatrics; and
- Develop and operate a physician assistant education program.

The Secretary may make 5 years grants to or contracts with schools of medicine or osteopathic medicine to establish, maintain, or improve:

- Academic units or programs that improve clinical teaching in family medicine, general internal medicine, or general pediatrics; or
- Programs that integrate academic administrative units to enhance interdisciplinary recruitment, training, and faculty development.

There are appropriated $125 million for 2010 and such sums as may be necessary for fiscal years 2011 through 2014, with 15 percent of funds in each fiscal year allocated to physician assistant training programs. An additional $750,000 for each of fiscal years 2010 through 2014 is appropriated for integrating academic units.

### Section 5302. Training Opportunities for Direct Care Workers

This section amends the Public Health Service Act to award grants to eligible entities that provide new training opportunities for direct care workers employed in long-term care settings. Funds will be used to provide financial assistance to individuals at an eligible entity who agree to work in the field of geriatrics, disability services, long-term services and supports, or chronic care management for a minimum of 2 years. There is allocated $10 million for the period 2011 through 2013.

### Section 5303. Training in General, Pediatric, and Public Health Dentistry

This section amends the Public Health Service Act to award 5-year grants to or contracts with a school of dentistry, hospital or nonprofit to:

- Plan, develop, and operate a training program in general, pediatric or public health dentistry with financial assistance to students;
- Plan, develop, and operate a training program for oral health providers who plan to teach in general, pediatric or public health dentistry with financial assistance to participants;
- Establish, maintain, or improve dental faculty development programs in primary care;
- Establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

- Create a loan repayment program for faculty in dental programs; and
- Provide technical assistance to pediatric training programs.

Priority will be given to applicants: proposing collaborative projects, with a record of training the greatest percentage of providers, with a record of training individuals from rural or disadvantaged areas, and have a high rate for placing graduates in practice settings that serve underserved areas or populations. There are appropriated $30 million for fiscal year 2010, and such sums as may be necessary for 2011 through 2015.

**Section 5304. Alternative Dental Health Care Providers Demonstration Project**

The Secretary will award grants to 15 eligible entities to establish a demonstration program to increase access to dental health care services in rural and underserved communities through training programs for alternative dental health care providers. There is appropriated such sums as may be necessary to carry out this section.

**Section 5305. Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education**

The Secretary will make grants or contracts to entities that operate a geriatric education center for:

- A fellowship program in geriatrics, chronic care management, and long-term care for faculty members in medical and health professional schools;
- Family caregiver and direct care provider training; and
- Incorporating materials on common mental disorders among older adults, medication safety issues, and communication techniques for working with individuals with dementia in appropriate training courses.

Grants will be awarded to no more than 24 geriatric education centers and will not exceed $150,000. A total of $10.8 million will be allocated for the period 2011-2014.

The Secretary will award grants or contracts to eligible individuals to foster greater interest among a variety of health care professionals to enter the field of geriatrics, long-term care, or chronic care management. An individual receiving an award under this section will agree to teach or practice in one of these fields for at least 5 years. A total of $10 million will be allocated for the period 2011-2013.

This Section amends the Public health Service act to expand the Geriatric Academic Career Awards to additional health professions faculty, and establishes traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing.

**Section 5306. Mental and Behavioral Health Education and Training Grants**

Grants may be made to eligible higher education institutions for the recruiting and education of students in social work, graduate psychology, training in child and adolescent mental health, and preservice or in-service training of paraprofessional child and adolescent mental health workers. For fiscal years 2010 through 2013 there is appropriated $8 million for social work training, $12 million for graduate psychology training, and $10 million for professional and $5 million for paraprofessional child and adolescent mental health training.

**Section 5307. Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training**

This section reauthorizes and expands programs for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, and public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. The Secretary will collaborate with relevant stakeholders in carrying this out. There are appropriated such sums as may be necessary for fiscal years 2010 through 2015.

**Section 5308. Advanced Nursing Education Grants**

Nurse midwifery programs must be accredited in order to be eligible for grants under section 811 of the Public Health Service Act.

**Section 5309. Nurse Education, Practice and Retention Grants**

This section amends the Public Health Service Act to authorize funding of nursing education grants through 2014. Nurse retention grants may be awarded to eligible entities for initiating and maintaining nurse retention programs, with funding for these grants authorized in such sums as may be necessary for 2010 through 2012.

**Section 5310. Loan Repayment and Scholarship Program**

Faculty at nursing schools will be eligible for loan repayment and scholarship programs.

**Section 5311. Nurse and Faculty Loan Program**

This section amends the Public Health Service Act to authorize funding of loans for the purpose of increasing nursing school faculty through 2014. A loan repayment program is also established where individuals agree to teach at an accredited program for at least 4 years. There are appropriated such sums as may be necessary for fiscal years 2010 through 2014.

**Section 5312. Authorization of Appropriations for Parts B through D of Title VIII**

This Act makes available $388 million for nurse workforce development for fiscal year 2010 and such sums as may be necessary for 2011 through 2016.

**Section 5313. Grants to Promote the Community Health Workforce**

The CDC will award grants to promote positive health behaviors and outcomes through the use of community health workers. Funds will be used for community health workers to educate, guide, and provide outreach, referrals, and home visitation services to populations in medically underserved areas. Entities receiving this funding will be encouraged to collaborate with academic institutions and use evidence-based interventions. There are appropriated such sums as may be necessary for fiscal years 2010 through 2014.

A community health worker is an individual who, within the community in which the individual resides, provides guidance, enhances residents' ability to communicate with health care providers, provides culturally and linguistically appropriate health or nutrition information, and provides referrals.

**Section 5314. Fellowships Training in Public Health**

The Secretary may address workforce shortages in State and local health departments in the areas of applied public health epidemiology and laboratory science and informatics, specifically by expanding fellowship programs in the CDC and similar training programs. There are allocated $39.5 million for each of fiscal years 2010 through 2013.

**Section 5315. United States Public Health Sciences Track**

U.S. Public Health Sciences Track will be established to grant advanced graduate degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness and response to students in medicine, dentistry, nursing, public health, behavioral and mental health, pharmacist, physician assistant or nurse practitioner programs at affiliated institutions. The Surgeon General will administer the Track, which will include programs for continuing medical education. Participants will receive tuition remission and stipends and commit to serve in the Commissioned Corps of the Public Health Service after completion of the Track.

## Subtitle E - Supporting the Existing Health Care Workforce

**Section 5401. Centers of Excellence**

The Centers of Excellence program, which supports programs in health professions education for minorities interested in health careers, is reauthorized and allocations formulas are revised. There is appropriated $50 million for each of fiscal years 2010 through 2015, with such sums as may be necessary for each subsequent year.

**Section 5402. Health Care Professionals Training for Diversity**

This section amends the Public Health Service Act to reauthorize and expand loan repayments for individuals who serve as faculty at eligible health professions institutions, scholarships for disadvantaged students, and educational assistance to identify, recruit, and retain disadvantaged students for health professions education. There is appropriated $51 million for 2010 and such sums as be necessary for 2011 through 2014 for the scholarship program, $5 million for each fiscal year 2010 through 2014 for the loan repayment program, and $60 million for 2010 and such sums as be necessary for 2011 through 2014 for educational assistance.

**Section 5403. Interdisciplinary, Community-Based Linkages**

The Secretary may make awards for eligible entities to initiate or continue health care workforce educational programs and make awards for eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program. Funds will be used to:

- Develop and implement strategies to recruit underrepresented minorities into health professions;
- Develop and implement strategies to provide community-based training and education;
- Prepare individuals to more effectively provide health services to underserved areas;
- Conduct and participate in interdisciplinary training;
- Deliver and facilitate continuing education to health care professionals; and
- Establish a youth public health program to expose and recruit students into health careers.

An eligible entity must be able to match an amount equal to 50 percent of grant funds with non-Federal contributions, with at least 25 percent in cash. There is authorized $125 million for each of fiscal years 2010 through 2014. It is the sense of the Congress that each State should have an area health education center program under this section.

The Secretary may make grants or enter into contracts with eligible entities to improve health care, increase retention, increase representation of minority faculty members, and enhance the practice environment through the timely dissemination of research findings. There is appropriated $5 million for each of fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent year.

**Section 5404. Workforce Diversity Grants**

Nursing workforce diversity grants will be expanded and will include stipends for bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities.

**Section 5405. Primary Care Extension Program**

AHRQ will establish a Primary Care Extension Program to educate and provide technical assistance to primary care providers about:

- Preventive medicine;
- Health promotion;
- Chronic disease management;
- Mental and behavioral health services; and
- Evidence based therapies and techniques.

The Secretary will award competitive program or planning grants for the establishment of State- or multistate-level Primary Care Extension Program State Hubs. The Hubs will include the State health department, entities responsible for administering the Medicaid and Medicare programs in the State, and the departments of one or more health professions schools in the State that train providers in primary care.

Hubs will assist primary care providers to implement patient-centered medical home, support learning communities to disseminate research findings for evidence based practice, and develop a plan for financial sustainability to facilitate the reduction in Federal funds expected after the initial 6 year program. There is authorized $120 million for each of fiscal years 2011 and 2012, and such sums as may be necessary for 2013 and 2014.

## Subtitle F - Strengthening Primary Care and Other Workforce Improvements

**Section 5501. Expanding Access to Primary Care Services and General Surgery Services**

Beginning January 1, 2011, primary care service practitioners will receive a 10 percent Medicare bonus payment for 5 years. General surgeons in underserved health care areas will also receive this bonus.

*(This section is modified in section 10501)*

**Section 5502. Medicare Federally Qualified Health Center Improvements**

*(This section is repealed in section 10501)*

**Section 5503. Distribution of Additional Residency Positions**

Beginning, July, 1, 2011, the Secretary may redistribute unfilled residency positions to qualifying hospitals, with preference given to hospitals with a low resident-to-population ration or in rural and health professional shortage areas.

**Section 5504. Counting Resident Time in Nonprovider Settings**

This section modifies rules about when hospitals can receive direct graduate medical education and indirect medical education funding for residents. All time spent in patient care activities in nonprovider settings may be counted if the hospital incurs the costs of stipends and fringe benefits. Effective July 1, 2010.

**Section 5505. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities**

Time spent by an intern or resident in an approved medical residency training program in non-patient care activities like didactic conferences and seminars may be counted toward the determination of full-time equivalency for direct graduate medical education and indirect medical education funding.

**Section 5506. Preservation of Resident Cap Positions from Closed Hospitals**

The Secretary will create a process for redistributing residency positions when a hospital with an approved medical residency program closes, with priority for an increase in the applicable resident limit given to hospitals located in the same core-based statistical areas.

**Section 5507. Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers**

The Secretary will award grants for demonstration projects designed to provide low-income individuals with the opportunity to obtain education and training for health care jobs that are expected to have labor shortages or be in high demand. Demonstration projects will provide financial support, child care aid, case management and other supportive services as appropriate. Demonstration projects will also consult and coordinate with the State Temporary Assistance for Needy Families (TANF) program and local and State workforce investment boards.

Within 18 months of enactment of this section, the Secretary will award grants to 6 States for demonstration projects that develop core training competencies and certification programs for personal or home care aides. Technical assistance will be provided to grant recipients and their training competencies will be evaluated.

A total of $85 million is appropriated for each of fiscal years 2010 through 2014 to carry out these demonstration projects, with $5 million of this amount allocated for each fiscal year 2010 through 2012 for personal or home care aide training and certification. Funding is extended for family-to-family health information centers through fiscal year 2012.

**Section 5508. Increasing Teaching Capacity**

The Secretary may award grants to teaching health centers to establish new accredited or expanded primary care residency programs. Such grants will have a term of no more than 3 years and be no more than $500,000. Eligible entities include Federally Qualified Health Centers, community mental health

centers, and health centers operated by the Indian Health Service, an Indian tribe or tribal organization. There are appropriated $25 million for 2010, $50 million for 2011, $50 million for 2012, and such sums as may be necessary for subsequent years.

*The Public Health Service Act is amended to allow an individual in a National Health Corps scholarship or loan repayment program up to count up to 50 percent of time spent teaching as part of his or her service obligation.*

The Secretary will make payments for direct and indirect expenses to qualified teaching health centers for expansion of existing or establishment of new graduate medical residency training programs. There are appropriated such sums as may be necessary to carry out this section, not to exceed $230 million for the period 2011 through 2015. Qualified teaching health centers will submit an annual report and may be audited.

*(This section is modified in section 10501)*

**Section 5509. Graduate Nurse Education Demonstration**

The Secretary will establish a graduate nurse education demonstration program under Medicare for up to 5 hospitals to provide clinical training to advance practice nurses. There is appropriated $50 million for each of fiscal years 2012 through 2015 to carry out this section.

## Subtitle G - Improving Access to Health Care Services

**Section 5601. Spending for Federally Qualified Health Centers (FQHCS)**

This section authorizes the following appropriations for FQHCs: $2.99 billion in 2010, $3.86 billion in 2011, $4.99 billion in 2012, $6.45 billion in 2013, $7.33 billion in 2014, and $8.33 billion in 2015, with appropriations increasing in 2016 and subsequent years based on the cost and number of patients served.

**Section 5602. Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Areas**

The Secretary will establish, through a negotiated rulemaking process, a comprehensive methodology and criteria for designating medically underserved populations and health professions shortage areas. The process will consider the timely availability and appropriateness of data, the impact of the methodology and criteria on communities and health centers, and the extent to which the methodology accurately measures various barriers that confront groups seeking heath care services.

**Section 5603. Reauthorization of the Wakefield Emergency Medical Services for Children Program**

This section reauthorizes a program to award grants to States and medical schools for the improvement and expansion of emergency medical services for children needing trauma or critical care treatment, and appropriates $25 million for 2010, $26 million for 2011, $27.5 million for 2012, $28.9 million for 2013, and $30.4 million for 2014.

**Section 5604. Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings**

The Secretary will award grants and cooperative agreements to establish demonstration projects that provide coordinated and integrated services by co-locating primary and specialty care services in community-based mental and behavioral health settings. There are authorized $50 million for fiscal year 2010 and such sums as may be necessary for 2011 through 2014.

**Section 5605. Key National Indicators**

A Commission on Key National Indicators will be established to conduct comprehensive oversight of a newly established key national indicators system, make recommendations on how to improve the system, and enter into contracts with the National Academy of Sciences. The Academy will enable the establishment of a Key National Indicators Institute by creating its own capacity or partnering with an appropriate nonprofit entity. The Comptroller General will conduct a study on best practices for a key national indicator system. There is appropriated $10 million for 2010 and $7.5 million for each of fiscal years 2011 through 2018 to carry out this section.

### Subtitle H - General Provisions

**Section 5701. Reports**

The Secretary will annually report on activities established under this title to the appropriate committees of Congress and may require entities receiving funds under this title to report on activities carried out.

# Title VI - Transparency and Program Integrity

### Subtitle A - Physician Ownership and Other Transparency

**Section 6001. Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals**

This section requires that physician-owned hospitals have a provider agreement on December 31, 2010, in order to participate in Medicare. Such hospitals must also meet requirements regarding expansion limitations, conflicts of interest, bona fide investments, and patient safety issues. The Secretary will establish policies and procedures to ensure compliance with requirements.

*(This section is modified in section 1106 of the Reconciliation Act)*

**Section 6002. Transparency Reports and Reporting of Physician Ownership or Investment Interests**

Beginning in 2012, any applicable manufacturer (drug, device, biological or medical supply) that provides a payment or other transfer of value to a covered recipient (physician or teaching hospital) will annually submit a report to the Secretary for the previous calendar year which includes:

- The name and address of the covered recipient;
- The amount and dates of the payment or other transfer of value; and

- A description of the form and nature of the payment or other transfer of value.

Any applicable manufacturer must also annually report information on physician ownership or investment in the applicable manufacturer or applicable group purchasing organization during the preceding year. Any applicable manufacturer that fails to submit information will be subject to a fine for each payment or transfer of value not reported up to $150,000. Any applicable manufacturer that knowingly fails to submit information will be fined up to $1 million. Any fines collected will be used to carry out this section.

The provisions of this section will preempt State law, except in the case where State law requires additional reporting beyond this section.

**Section 6003. Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services**

Physicians are required to inform a patient in writing at the time a referral is made that the individual may obtain certain services from a person other than the referring physician or a member of the referring physician's practice and provide such individual with a list of suppliers who provide the service

**Section 6004. Prescription Drug Sample Transparency**

Beginning in 2012, drug manufacturers and authorized distributors of applicable drugs will submit to the Secretary information about the identity and quantity of drug samples requested and distributed.

**Section 6005. Pharmacy Benefit Managers Transparency Requirements**

This section requires a health benefits plan or any entity that provides pharmacy benefits management services (PBM) that manages prescription drug coverage under a contract with health plans under Medicare or an Exchange to report to the Secretary information regarding:

- Generic dispensing rate;
- Rebates, discounts, or price concessions negotiated by the PBM; and
- Differences between the amount the health benefits plan pays the PBM and the amount the PBM pays pharmacies.

Information disclosed by a health benefit plan or PBM under this section is confidential, with certain exceptions. There will be penalties for a health benefit plan or PBM that fails to provide information in a timely manner or knowingly provides false information.

## Subtitle B - Nursing Home Transparency and Improvement

**Part I - Improving Transparency of Information**

**Section 6101. Required Disclosure of Ownership and Additional Disclosable Parties Information**

Beginning on the date of enactment of this Act, nursing facilities must make information on ownership, including a description of the governing body and organizational structure of the facility, and information on additional discloasable parties available upon request to the Secretary, the Inspector General of HHS, the State, and the State long-term care ombudsman.

**Section 6102. Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities**

Within 3 years of the enactment of this Act, nursing facilities will have a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations. The Secretary will evaluate such programs and report findings and recommendations to Congress.

The Secretary will establish and implement a quality assurance and performance improvement program for nursing facilities by December 31, 2011. The program will establish standards relating to quality assurance and performance improvement at facilities and provide technical assistance on best practices.

**Section 6103. Nursing Home Compare Medicare Website**

HHS will provide the following information on the Nursing Home Compare Medicare website in a manner that is updated on a timely basis, easily accessible, and searchable:

- Staffing data for each facility;
- Links to State websites regarding State survey and certification programs;
- The standardized complaint form;
- Summary information on substantiated complaints;
- The number of adjudicated instances of criminal violations by a facility or its employee; and
- The number of civil monetary penalties levied against the facility, employees, and other agents.

The Secretary will establish a process to review the accuracy, clarity, and comprehensiveness of information on such website and within a year will make appropriate modifications. Each State will submit information related to a nursing facility survey or certification to the Secretary by the date the State sends such information to the facility.

The Secretary will conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that have failed to meet requirements. A skilled nursing facility must have reports on surveys, certifications, and complaint investigations from the past 3 years available for any individual to review upon request and post notice of the availability of such reports in the facility.

**Section 6104. Reporting on Expenditures**

Cost reports submitted under Medicare and Medicaid by skilled nursing facilities will separately report expenditures for wages and benefits for direct care staff. The Secretary will redesign such reports prior to this requirement taking effect. The Secretary will categorize expenditures on an annual basis for each facility in the following accounts: spending on direct care, spending on indirect care, capital assets, and administrative services costs. This information will be available to interested parties upon request.

**Section 6105. Standardized Complaint Form**

The Secretary will develop a standardized complaint form for residents in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program. The State must establish a complaint resolution process that includes procedures for accurate tracking, determining the severity of, and investigating complaints and deadlines for responding to a complaint.

**Section 6106. Ensuring Staffing Accountability**

The Secretary will require nursing facilities to electronically submit direct care staffing information in a uniform format based on payroll data which includes category of work performed, resident census data, and employee turnover and tenure.

**Section 6107. GAO Study and Report on Five-Star Quality Rating System**

The Comptroller General, operating from the Government Accountability Office (GAO), will conduct a study on the Five-Star Quality Rating System for nursing homes of the CMS, which will include an analysis of how the system is being implemented, any problems associated with implementation, and how it may be improved.

**Part II - Targeting Enforcement**

**Section 6111. Civil Money Penalties**

The Secretary may reduce civil money penalties by up to 50 percent when a nursing facility self-reports and promptly corrects a deficiency within 10 calendar days. A facility may appeal penalties through a dispute resolution process, in which case the civil money penalty collected would be placed in an escrow account until the appeal is resolved. If the appeal is successful, the facility will have the amount returned. If the appeal is unsuccessful, some portion of the amount collected may be used for activities that benefit residents. Effective date is one year after the date of enactment of this Act.

**Section 6112. National Independent Monitor Demonstration Project**

The Secretary will conduct a 2-year demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. The Secretary will select facilities to participate from among those submitting an application. The demonstration project will begin within 1 year of implementation of this Act.

The Secretary will contract with an independent monitor to:

- Conduct periodic reviews and prepare analyses to assess if facilities of the chain are in compliance with State and Federal laws and regulations;
- Conduct oversight of efforts to achieve compliance by facilities with State and Federal laws;
- Analyze the management structure, distribution of expenditures, and nurse staffing levels;
- Report findings and recommendations to the Secretary and relevant States; and
- Publish the results of such reviews, analyses, and oversight.

After getting notice of a finding by the monitor, a chain will have 10 days to submit a report outlining corrective actions or indicate the reasons it will not implement recommendations. A chain will be responsible for a portion of the costs associated with having a monitor under the demonstration project. There are authorized such funds as may be necessary to carry out this section. The Secretary will evaluate the project and recommend if the independent monitor program should be established on a permanent basis.

**Section 6113. Notification of Facility Closure**

A nursing facility administrator must submit to the Secretary, the State long-term care ombudsman, residents of the facility, and legal representatives of such residents a written notification of impending

closure no later than 60 days prior to closure. The facility may not admit any new residents after the date notification is submitted. The notification must include a plan for the transfer and adequate relocation of residents. An administrator that fails to provide adequate notification will be subject to a civil monetary penalty up to $100,000, be prohibited from participating in any Federal health care program, and will be subject to other penalties. Effective date is one year after the date of enactment of this Act.

**Section 6114. National Demonstration Projects on Culture Changes and Use of information Technology in Nursing Homes**

The Secretary will conduct two 3-year demonstration projects, 1 for the development of best practices of nursing facilities that are involved in the culture change movement, and 1 for the development of best practices in nursing facilities for the use of information technology to improve care. Under each, the Secretary will award competitive, lump-sum grants to facility-based settings for the development of best practices. There are authorized such funds as may be necessary to carry out this section.

**Part III - Improving Staff Training**

**Section 6121. Dementia and Abuse Prevention Training**

Nursing facilities will include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract staff, and, if the Secretary determines appropriate, as part of ongoing training. Effective date is 1 year after the date of the enactment of this Act.

## Subtitle C - Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

**Section 6201. Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers**

The Secretary will establish a program to identify efficient, effective, and economical procedures for long-term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis. The program will be based on a pilot program in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The Secretary will enter into agreements with each State that agrees to conduct background checks on a statewide basis under the nationwide program and submits an application. A participating State will:

- Conduct screening and criminal history background checks;
- Monitor compliance by long-term care facilities and providers;
- Provide a process for a provisional employee to appeal or dispute the accuracy of a background check; and
- Designate a single State agency to coordinate and oversee the program and report background check results to requesting long-term care facilities and providers.

There will be a Federal match up to three times the amount participating Sate make available. The Inspector General of HHS will conduct an evaluation of the nationwide program and will submit a report to Congress. There is appropriated up to $160 million to carry out this section for fiscal years 2010 through 2012, and no more than $3 million may be used for evaluation.

## Subtitle D - Patient-Centered Outcomes Research

### Section 6301. Patient-Centered Outcomes Research

A Patient-Centered Outcomes Research Institute will be established as a nonprofit corporation. The Institute will receive funding from the Patient-Centered Outcomes Research Trust (PCORTF). The Institute will advance the and relevance of evidence on how health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and dissemination of research findings. Duties of the Institute include:

- Identifying research priorities and establishing a research project agenda;
- Carrying out the research agenda through systemic reviews and primary research;
- Appropriately using data gathered by CMS in accordance with laws and regulations regarding confidentiality and privacy;
- Appointing advisory panels as appropriate to assist in identifying priorities and establishing the agenda;
- Providing support and resources to help patient and consumer representatives participate on the Board and advisory panels appointed by the Institute;
- Establishing a methodology committee to develop and improve methods for comparative research;
- Providing a process for peer review of primary research;
- Making research findings publicly available within 90 days of their receipt; and
- Submitting annual reports to Congress and making such reports available to the public.

The Institute will have a Board of Governors that represents a broad range of perspectives and expertise, which includes 17 appointed members and the Directors of AHRQ and NIH. Nothing in this section permits the Institute to mandate coverage or reimbursement policies for any payer.

The Office of Communication and Knowledge Transfer at AHRQ will disseminate research findings published by the Institute and create informational tools that organize and disseminate research findings for health care providers, patients, payers, and policy makers. The AHRQ will build capacity for comparative clinical effectiveness research through a grant program to provide training to researchers.

The PCORTF is appropriated the following sums: $10 million for 2010, $50 million for 2011, $150 million for 2012, and for fiscal years 2013 through 2019 $150 million plus net revenues from fees on health insurance and self-insured plans.

The Internal Revenue Code is amended to impose a fee on specified health insurance policies and self-insured health plans for each policy year ending after September 30, 2012, through September 30, 2019, to be paid by the issuer of the policy or plan sponsor.

### Section 6302. Federal Coordinating Council for Comparative Effectiveness Research

Upon the date of enactment of this Act, the Federal Coordinating Council created in the American Recovery and Reinvestment Act will be terminated.

## Subtitle E - Medicare, Medicaid, and CHIP Program Integrity Provisions

### Section 6401. Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP

The Secretary will establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. The Secretary will determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, all providers and suppliers will be subject to licensure checks. Additional screening may include criminal background checks, fingerprinting, site visits, and database checks.

*An application fee for providers and suppliers will be imposed to cover the cost of screening.* The fee may be waived for a provider or supplier if it would result in a hardship or impede access to care in Medicaid.

A provider or supplier who submits an application for enrollment or revalidation in Medicare, Medicaid, or CHIP, will disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had payments suspended, has been excluded from participating in a Federal health care program, or has had its billing privileges revoked. The Secretary may deny applications if such affiliations pose a risk of fraud, waste, or abuse.

The Secretary may make adjustments to payments to an applicable provider or supplier to satisfy any past-due obligations. A provider or supplier may be required to establish a compliance program in consultation with the Inspector General.

CMS will establish a process for making information on providers terminated from Medicare or CHIP available to a State agency administering Medicaid.

*(This section is modified in section 10603)*

### Section 6402. Enhanced Medicare and Medicaid Program Integrity Provisions

The Integrated Data Repository of CMS will include claims and payment data from Medicare (Parts A, B, C and D), Medicaid, CHIP, and health-related programs administered by the Departments of Veteran Affairs and Defense, the Social Security Administration, and the Indian Health Service. The Secretary will enter into agreements to share and match data with these agencies to help identify fraud, waste, and abuse. The Inspector General and Attorney General will have access to claims and payment data to conduct law enforcement and oversight activities consistent with applicable privacy, security, and disclosure laws.

If an overpayment is made, the applicable entity has 60 days to report and return the overpayment. The Secretary will issue regulations that providers and suppliers under Medicare, Medicaid, and CHIP must include their national provider identifier on all applications and claims under such programs.

Payment may be withheld to a State that does not report enrollee encounter data to the Medicaid Statistical Information System in a timely manner. Providers or suppliers who make a false statement or misrepresentation on any application to enroll or participate in a Federal health care program may be excluded from all Federal health care programs.

Civil monetary penalties are expanded to include excluded individuals or entities that order or prescribe a medical service and individuals or entities that knowingly make false statements or misrepresentations in

an application to a Federal health care program or does not report and return a known overpayment. Each violation will be subject to civil money penalties up to $50,000.

The Secretary may suspend Medicare and Medicaid payments to a provider or supplier pending an investigation of a credible allegation of fraud. An additional $10 million is appropriated for each of fiscal years 2011 through 2020 to fight fraud and abuse.

Entities that have contracts with the Medicare and Medicaid Integrity Programs will be required to provide performance statistics, including the number and amount of overpayments recovered, number of fraud referrals, and the return on investment for such activities. The Secretary will conduct an evaluation of the programs and submit a report to Congress.

**Section 6403. Elimination of Duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank**

The Secretary will maintain a national health care fraud and data abuse collection program for reporting certain final adverse actions against health care providers and suppliers. This information will be submitted to the National Practitioner Data Bank. Fees may be established for the disclosure of information to cover the cost of processing.

The State must have a system of reporting information on any final adverse action taken against a health care provider or supplier by a State law or fraud enforcement agency.

Effective on the date of enactment of this Act, the Secretary will implement a transition process to end and transfer all data collected by the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank. The Department of Veterans Affairs will be able to access this data bank for 1 year with no fees.

**Section 6404. Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months**

The maximum timeframe to submit Medicare claims will be reduced to 1 calendar year after date of service, effective beginning January 1, 2010.

**Section 6405. Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals**

Durable medical equipment or home health services must be ordered by a Medicare eligible professional or physician enrolled in the Medicare program. The Secretary is authorized to extend this requirement to other services. These requirements are effective July 1, 2010.

**Section 6406. Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse**

Beginning July 1, 2010, the Secretary may revoke Medicare enrollment, for a period up to 1 year per act, a physician or supplier who fails to maintain and, upon request of the Secretary, provide access to documentation of written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other services.

**Section 6407. Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services of Durable Medical Equipment under Medicare**

Physicians must have a face-to-face encounter with a Medicare or Medicaid beneficiary before issuing a certification for home health services or durable medical equipment. A face-to-face encounter may be required for other services under Medicare based on a finding that it would reduce the risk of waste, fraud, or abuse.

*(This section is modified in section 10605)*

**Section 6408. Enhanced Penalties**

Any person who knowingly makes a false record or statement related to a false claim under a Federal health care program or fails to grant timely access to the Inspector General of HHS for an audit or investigation may be subject to civil monetary penalties of $50,000 for each false statement and $15,000 for each day access is denied.

Medicare Advantage or Part D plans may be subject to sanctions and civil money penalties for enrolling people without their consent, transferring people from one plan to another to earn a commission, failing to comply with marketing requirements, or employing an individual or entity that commits a violation.

**Section 6409. Medicare Self-Referral Disclosure Protocol**

Within 6 months of enactment, the Secretary will establish a self-referral disclosure protocol (SDRP) to enable health care providers and suppliers to disclose an actual or potential violation of the physician referral law. The Secretary will post information on the CMS website on how to disclose actual or potential violations.

The Secretary is authorized to reduce penalties for physician referral violations. The Secretary will submit a report to Congress on the implementation of SDRP that includes the number of providers and suppliers making disclosures, the amount collected, and the types of violations reported.

**Section 6410. Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Acquisition Program**

The Secretary will expand the number of areas to be included in round two of the competitive bidding program to 100 of the largest metropolitan statistical areas and use competitively bid prices by 2016.

**Section 6411. Expansion of the Recovery Audit Contractor (RAC) Program**

By December 31, 2010, the Secretary will establish a program under which the State contracts with one or more recovery audit contractors to identify underpayments and overpayments and recoup overpayments made under Medicaid. The use of recovery audit contractors will be expanded to Medicare Parts C and D.

## Subtitle F - Additional Medicaid Program Integrity Provisions

**Section 6501. Termination of Provider Participation under Medicaid if Terminated Under Medicare or Other State Plan**

The State will be required to terminate an individual or entity that if the individual or entity was terminated from Medicare or another State's Medicaid program.

**Section 6502. Medicaid Exclusion From Participation Relating to Certain Ownership, Control, and Management Affiliations.**

The States will exclude individuals or entities from participating in Medicaid for a specified period of time if the individual owns, controls, or manages an entity that has unpaid overpayments, is suspended or excluded from participating in Medicaid, or is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid.

**Section 6503. Billing Agents, Clearinghouses or Other Alternate Payees Required to Register Under Medicaid**

Any agent, clearinghouse, or alternate payee that submits claims on behalf of a health care provider must register with the State and the Secretary.

**Section 6504. Requirement to Report Expanded Set of Data Elements under MMIS to Detect Fraud and Abuse**

States and Medicaid managed care entities must submit data elements from Medicaid Management Information System as deemed necessary for program integrity, program oversight, and administration.

**Section 6505. Prohibition on Payments to Institutions or Entities Located Outside of the United States**

States will not provide any payments for items or services provided under a Medicaid plan or waiver to any financial institution or entity located outside of the United States.

**Section 6506. Overpayments**

States will have 1 year to recover overpayments made to a provider from the date of discovery. If a State is unable to recover an overpayment due to fraud within a year because a final determination has not been made, no adjustment will be made in Federal payment until 30 days after a final judgment is made.

**Section 6507. Mandatory State Use of National Correct Coding Initiative**

States will be required to make their Medicaid Management Information System methodologies compatible with the National Correct Coding Initiative by October 1, 2010. The Secretary will identify and notify States of methodologies and how to incorporate them.

**Section 6508. General Effective Date**

Unless otherwise specified, amendments made by this section will take effect on January 1, 2011.

## Subtitle G - Additional Program Integrity Provisions

### Section 6601. Prohibition on False Statements and Representations

No person who is connected with a plan or other multiple employer welfare arrangements may make false statements in connection with marketing such a plan or arrangement, including the financial condition or solvency, benefits provided, or the regulatory status of the plan or arrangement.

### Section 6603. Development of Model Uniform Report Form

The Secretary will request that the National Association of Insurance Commissioners develop a model uniform reporting form for private health insurance issuers to report suspected cases of fraud and abuse.

### Section 6604. Applicability of State Law to Combat Fraud and Abuse

The Department of Labor may adopt regulatory standards to prevent people involved in fraudulent multiple employer welfare arrangements from using State law to escape liability for their actions by claiming that State law enforcement is preempted by Federal law.

### Section 6605. Enabling the Department of Labor to Issue Administrative Summary Cease and Desist Orders and Summary Seizures Orders Against Plans That Are in Financially Hazardous Condition

The Department of Labor may issue a cease and desist order to for a multiple employer welfare agreement that is engaged in fraud or poses a serious threat to the public until a hearing can be completed. Based upon the hearing, the cease and desist order will be affirmed, modified or set aside. If it is affirmed, the agency may seize the plan's assets.

### Section 6606. MEWA Plan Registration With Department of Labor

Multiple employer welfare arrangements (MEWA) will be required to file their Federal registration forms before enrolling people into the plan.

### Section 6607. Permitting Evidentiary Privilege and Confidential Communications

This section enables the Department of Labor to allow confidential communication among public officials of certain State and Federal agencies related to the investigation, audit, examination, or inquiry conducted by these agencies on fraud and abuse.

## Subtitle H - Elder Justice Act

### Section 6701. Short Title of Subtitle

The subtitle may be cited as the "Elder Justice Act of 2009."

### Section 6702. Definitions

The terms used in this subtitle have the same definition as section 2011 of the Social Security Act.

**Section 6703. Elder Justice**

Elder Justice: efforts to prevent, detect, treat, intervene in and prosecute elder abuse, neglect and exploitation, and efforts to protect elders with diminished capacity while maximizing their autonomy.

Fiduciary: a person or entity with the legal responsibility to make decisions on the behalf of and for the benefit or another person.

Long-Term care: supportive and health services for individuals who need assistance due to the loss of capacity for self-care, including eating, dressing, bathing, and managing one's financial affairs.

An Elder Justice Coordinating Council will be established to make recommendations to the Secretary for coordinating the activities of relevant Federal, State, local and private agencies and entities relating to elder abuse, neglect, and other crimes against elders. The Council will be advised by an Advisory Board on Elder Abuse, Neglect, and Exploitation that will also create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice. For this subpart here is appropriated $6.5 million for 2011, and $7 million for each of fiscal years 2012 through 2014.

The Secretary will coordinate with the Attorney General to make grants to eligible entities to establish and operate a total of 10 stationary and mobile forensic centers, to develop forensic expertise, and to provide services relating to elder abuse, neglect, and exploitation. There is authorized $4 million for 2011, $6 million for 2012, and $8 million for each of fiscal years 2013 and 2014.

The Secretary will coordinate with the Secretary of Labor to make grants to recruit and train long-term care staff. The Secretary will make grants to eligible entities to provide training and technical assistance on management practices to promote staff retention. The Secretary may make grants to long-term care facilities to offset the cost of implementing EHR technology. There are allocated $20 million for 2011, $17.5 million for 2012, and $15 million for each of fiscal years 2013 and 2014.

The Department of Health and Human Services will:

- Provide funding to State and local adult protective services;
- Collect and disseminate data relating to elder abuse and neglect;
- Disseminate information on best practices; and
- Provide technical assistance to States and other entities that provide adult protective services.

There are authorized $3 million for 2011, and $4 million for each of fiscal years 2012 through 2014.

The Secretary will annually award grants to States for enhancing adult protection services. There are appropriated $100 million for each fiscal year 2011 through 2014. The Secretary will award grants to States for demonstration programs to test methods and training modules for detecting elder abuse and neglect. There is allocated $25 million for each of fiscal years 2011 through 2014. The Secretary will make grants to improve and support State long-term care ombudsman programs. There is authorized $5 million for 2011, $7.5 million for 2012, and $10 million for 2013 through 2014.

A National Training Institute for Federal and State surveyors will be established to provide and improve the training of surveyors relating to abuse and neglect in programs and long-term care facilities paid under Medicare and Medicaid. There are appropriated $12 million for the period 2011 through 2014. The Secretary will make grants to State agencies that survey nursing facilities under Medicare and Medicaid. There are allocated $5 million for each of fiscal years 2011 through 2014.

Owners, operators, and employees of long-term care facilities receiving Federal funds will be required to report suspected crimes committed against a resident. Failure to report will result in a civil monetary penalty and may lead to exclusion from participating in any Federal health care program.

The Secretary will conduct a study on establishing a national nurse aide registry and report findings and recommendations to Congress and the Elder Justice Coordinating Council. Funding for the study will not exceed $500,000.

### Subtitle I - Sense of the Senate Regarding Medical Malpractice

#### Section 6801. Sense of the Senate Regarding Medical Malpractice

It is the sense of the Senate that States should be encouraged to develop and test alternatives to the existing civil litigation system to improve patient safety, reduce medical errors, and encourage efficient resolution of disputes while preserving an individual's right to seek redress in court. Congress should consider establishing a State demonstration program for this purpose.

## Title VII - Improving Access to Innovative Medical Therapies

### Subtitle A - Biologics Price Competition and Innovation

#### Section 7001. Short Title

The subtitle will be called "Biologics Price Competition and Innovation Act of 2009."

#### Section 7002. Approval Pathway for Biosimilar Biological Products

The Secretary will license biological products shown to be biosimilar to or interchangeable with a licensed biological product (reference product). If a biological product is interchangeable with a reference product and receives a license, subsequent applications using the same reference product will be prohibited for at least 1 year. Biosimilar licensing will be prohibited for the 12-year period after the reference product was licensed. An application for a biosimilar product may be filed 4 years after the license date of the reference product.

The Secretary may issue guidance with respect to the licensure of biological products, with a period for public comment. The Secretary may also issue product class-specific guidance.

A person submitting an application under Subsection (k) will provide confidential access to the owner of a patent licensed to a reference product sponsor and attorneys for the reference product sponsor for the purpose of determining if a patent infringement claim can be made. The reference product sponsor and Subsection (k) applicant will engage in good faith negotiations to determine if there is need for an action for patent infringement.

Biosimilar means that the biological product is highly similar to the reference product and there is no clinically meaningful difference between the biological product and the reference product in terms of

safety, purity, and potency. Interchangeable means the biological product may be substituted for the reference product with the intervention of the health care provider who prescribed the reference product.

The Secretary will develop recommendations for the review process of biolimilar biological product applications for the first 5 fiscal years after 2012 to be presented to Congress by January 15, 2012. The Secretary will collect and evaluate data regarding the costs of reviewing applications for biological products. There is appropriated such sums as may be necessary for each of fiscal years 2010 through 2012.

**Section 7003. Savings**

The Secretary of the Treasury will for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of the Biologics Price Competition and Innovation Act of 2009. These savings will be used for deficit reduction.

## Subtitle B - More Affordable Medicines for Children and Underserved Communities

**Section 7101. Expanded Participation in 340B Program**

This section amends the Public Health Service Act to expand a drug discount program to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

*(This section is modified in section 2302 of the Reconciliation Act)*

**Section 7102. Improvements to 340B Program Integrity**

This section modifies Section 340B of the Public Health Act which established a discount drug program. In order to prevent overcharges and other violations of the discounted pricing requirements specified in this section, the Secretary will establish a system to verify the accuracy of ceiling prices calculated by manufacturers and charged to covered entities including:

- Developing and publishing defined standards and methods for calculating ceiling prices;
- Regularly comparing ceiling prices;
- Performing spot checks of sales transactions; and
- Determining the cause and taking corrective action for any discrepancies.

Procedures will be established for manufacturers to issue refunds in the event of an overcharge. A password protected website will be available to covered entities to access applicable ceiling prices for covered drugs. A mechanism will be developed for reporting manufacturer rebates and other discounts to other purchasers and so appropriate credits and refunds are issued to covered entities. There will also be selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program. Civil money penalties may be applied to any manufacturer that knowingly and intentionally overcharges a covered entity.

In order to prevent diversion and violations of the duplicate discount provision by covered entities, the Secretary will:

- Develop procedures to enable and require covered entities to regularly update information on the HHS website;
- Develop a system to verify the accuracy of information listed on the website;

- Develop detailed guidance and options for billing covered drugs to State Medicaid agencies;
- Establish a universal, standardized identification system for facilitating the ordering, purchasing, and delivery of covered drugs; and
- Impose sanctions.

The Secretary will publish regulations to establish and implement an administrative process for resolving claims including procedures for remedies and enforcement of determinations within 180 days. There are authorized such sums as may be necessary to carry out this subsection for the fiscal year 2010 and each succeeding fiscal year.

**Section 7103. GAO Study to Make Recommendations on Improving the 340B Program**

The Comptroller General will submit a report to Congress examining whether the individuals served under section 340B of the Public Health Service Act are receiving optimal health care services. The report will include recommendations on whether:

- The program should be expanded;
- Mandatory sales of certain products by the 340B program could hinder patient access to those therapies through any provider; and
- The income from the 340B program is being used by covered entities to further program objectives.

# Title VIII - CLASS Act

**Section 8001. Short Title**

This title may be cited as the "Community Living Assistance Services and Supports Act" or the CLASS Act.

**Section 8002. Establishment of National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support**

This title establishes a national insurance program for purchasing community living assistance services and supports that allow for personal and financial independence for individuals with functional limitations.

Eligible beneficiary: a person who is an active enrollee in the CLASS program, has paid premiums in the program for at least 60 months, has paid premiums for at least 24 consecutive month, and s has earned at least an amount equal to the income requirement to be credited with a quarter of Social Security coverage.

The Secretary will develop at least 3 actuarially sound benefit plans as alternatives for consideration as the CLASS Insurance Benefit Plan. The premiums for the plan will ensures solvency of the program for 75 years and will not exceed $5 a month (annually adjusted by the consumer price index) for individuals with income at the poverty line or who are under age 22 and a full-time student.

There will be a 5-year vesting period for eligibility for benefits. Benefits will be triggered when there is a determination that an individual has a functional impairment certified by a licensed health care practitioner that is expected to last for a continuous period of more than 90 days. The benefit amount will

be at least an average of $50 per day and will be paid or a daily or weekly basis. The benefits allow for coordination with any supplemental coverage purchased through an Exchange.

The CLASS Independence Advisory Council will evaluate the alternative benefit plans and recommend the plan that best balances price and benefits for enrollees while optimizing the long-term sustainability of the CLASS Program. By October 1, 2012, the Secretary will designate a plan to be the CLASS Benefit Plan, taking into consideration the Council's recommendation.

Premiums will remain the same as long as an individual is an active enrollee in the program with the following exceptions:

- It is determined that monthly premiums and income to the CLASS Independence Fund are projected to be insufficient with respect to a 20-year period;
- If an individual reenrolls after failing to pay premiums for 90 days;
- An individual is no longer a full-time student; and
- If an individual reenrolls after 5 years of initial participation in the program.

The Secretary, in coordination with the Secretary of the Treasury, will establish procedures so an individual may be automatically enrolled in the CLASS program by an employer in the same way an employer may elect to automatically enroll employees in a 401(k) plan, with an amount equal to monthly premiums deducted from wages. An alternate enrollment process will be established for an individual who is self-employed, has more than 1 employer, or whose employer does not elect to participate in the automatic enrollment process. An individual may choose to waive enrollment in the CLASS program.

By January 1, 2012, the Secretary will:

- Establish an Eligibility Assessment System for assessments of active enrollees who apply for benefits;
- Enter into an agreement with the Protection and advisory System for each State to provide advocacy services; and
- Enter into an agreement with public and private entities to provide advice and assistance counseling.

An individual will be deemed presumptively eligible if the enrollee has applied for the maximum cash benefit available under the sliding scale, is a patient in a hospital, nursing facility or institution for mental disease, and is in the process of or about to be discharged from such a facility.

Benefits include a cash benefit, advocacy services, and advice and assistance counseling services. Each eligible beneficiary will have cash benefits paid into a Life Independence Account and these funds will be used for nonmedical services and supports that the beneficiary needs to maintain independence at home. An eligible beneficiary will periodically recertify eligibility and submit records of expenditures attributable to the aggregate cash benefit received the preceding year. Benefits will supplement, not supplant, other health care benefits a beneficiary is eligible for under Medicaid or any other Federally funded program. Benefits paid to an eligible beneficiary will be disregarded in determining or continuing the beneficiary's eligibility for benefits under any other Federal, State or locally funded assistance program.

The CLASS Independence Fund will be established in the Treasury of the United States as a trust fund. The Fund will be used to hold investments on behalf of individuals enrolled in the CLASS program, pay administrative expenses related to the fund, and to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan. The Fund will be governed by a Board of Trustees who will annually report the status of the Fund to Congress and review the general policies for managing the Fund.

The Secretary will regularly consult with the Board of Trustees and the CLASS Independence Advisory Council to ensure that premiums are adequate to ensure the financial solvency of the CLASS program in the near-term and over 20- and 75-year periods. No taxpayer fund will be used for payments of benefits under a CLASS Independent Benefit Plan.

The Inspector General of HHS will submit an annual report to the Secretary and Congress on the overall progress of the CLASS program and any waste, fraud, and abuse relating to it.

Within 2 years of enactment of this Act, each State will:

- Assess the extent to which entities are serving or have the capacity to serve as fiscal agents, employers of, and providers of employment-related benefits for personal care attendant workers providing services to CLASS program beneficiaries;
- Designate or create entities to serve as fiscal agents, employers of, and providers of employment-related benefits for such workers to ensure an adequate supply of workers; and
- Ensure that the designation or creation of such entities will not impede existing programs, models or methods of service delivery.

Within 90 days of the enactment of this Act, the Secretary will establish a Personal Care Attendants Workforce Advisory Panel to examine and advise the Secretary and Congress on workforce issues related to personal care attendants. Information about the CLASS program and coverage available in the Exchange will be included in the National Clearinghouse for Long-Term Care Information. Funding for the Clearinghouse is extended through 2015.

# Title IX - Revenue Provisions

## Subtitle A - Revenue Offset Provisions

### Section 9001. Excise Tax on High Cost Employer-Sponsored Health Coverage

This section amends the Internal Revenue code to impose a tax of 40 percent on any applicable employer-sponsored coverage. Applicable plans in 2018 will be above the threshold of $10,200 for single coverage and $27,500 for family coverage. In subsequent years this amount will be increased by the cost-of-living adjustment plus 1 percent. There are exceptions for qualified retirees and individuals in a high-risk profession that increase the threshold by $1,650 for single coverage and $3,450 for family coverage.

The coverage provider (health insurance issuer, employer, or person that administers the plan benefits) will pay the tax imposed by this section. Each employer will calculate the amount of the excess benefit subject to the tax and notify the Secretary and each coverage provider. The plan sponsor will make this calculation for a multiemployer plan.

Applicable employer-sponsored coverage is coverage under a group health plan made available to an employee by an employer which is excluded from the employee's gross income. Coverage under any group health plan for a self-employed individual and coverage under any group health plan established and maintained by the Federal or State government for its civilian employees will be considered an applicable plan.

If the excise tax is miscalculated by the employer or plan sponsor, than the employer or plan sponsor will pay any of its share of the excise tax and a penalty equal to the cost of the excess, plus interest. No penalty will be applied where the employer or plan sponsor did not or could not have known of the error; where the failure was due to a reasonable cause and was corrected within 30 days; or where the Secretary waives the penalty as excessive.

These amendments will apply to tax years beginning after December 31, 2017.

*(This section is modified in section 1401 of the Reconciliation Act)*

**Section 9002. Inclusion of Cost of Employer-Sponsored Health Coverage on W-2**

The Internal Revenue Code is amended to include the aggregate cost of applicable employer-sponsored coverage on an employee's annual W-2 Form. This is effective for taxable years beginning after December 31, 2010.

**Section 9003. Distributions for Medicine Qualified Only If for Prescribed Drug or Insulin**

A qualified medical expense for medications or drugs under a health savings account (HSA), Archer medical savings account (MSA), flexible spending arrangement (FSA) and health reimbursement arrangement (HRA) will only include prescribed drugs (regardless of whether such drug is available without a prescription) and insulin. These changes will be effective on expenses incurred after December 31, 2010.

**Section 9004. Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses**

This section amends the Internal Revenue code to increase the tax for a nonmedical expense withdrawal from a health savings account or Archer medical savings account to 20 percent effective after December 31, 2010.

**Section 9005. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans**

Contributions to flexible spending arrangements are limited to $2,500 per year beginning January 1, 2013.

*(This section is modified in section 1403 of the Reconciliation Act)*

**Section 9006. Expansion of Information Reporting Requirements**

This section amends the Internal Revenue Code to require corporations that pay more than $600 during the year to corporate and non-corporate providers of property and services to file an information report with the IRS. This will apply to payments made after December 31, 2011.

**Section 9007. Additional Requirements for Charitable Hospitals**

This section amends the Internal Revenue Code to establish new requirements for nonprofit hospitals. These include:

- Conducting a community health needs assessment annually or every 3 years and adopting an implementation strategy to meet needs identified;

- Having a written financial assistance policy that includes eligibility criteria, the basis for calculating amounts charged to patients, the method for applying for financial assistance, and measures to widely publicize the policy within the community served;
- Limiting the amounts charged for emergency or other medically necessary care provided to individuals eligible under the financial assistance policy; and
- Not engaging in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible under the financial assistance policy.

Any hospital that fails to meet the requirement for a community needs assessment and implementation plan in any taxable year is required to pay a tax equal to $50,000. The Secretary of the Treasury will review the community benefit activities of each applicable hospital organization at least every 3 years. Each applicable hospital organization will submit:

- A description of how the organization is addressing needs identified in the community health needs assessment; and
- The audited financial statements of such organization.

The Secretary of the Treasury will report annually to Congress on hospitals regarding the levels of charity care provided, bad debt expense, unreimbursed costs, and costs incurred for community benefit activities. The Secretary of the Treasury will conduct a study on the trends in this information and, within 5 years of the enactment of this Act, will submit a report to Congress.

**Section 9008. Imposition of Annul Fee on Branded Prescription Pharmaceutical Manufacturers and Importers**

Each covered entity that manufactures or imports branded prescription drugs will pay an annual fee. The fee will equal *an applicable amount that changes over time* across all covered entities. Each entity will pay a ratio relative to such entity's branded prescription drug sales and the aggregate branded prescription drug sales across all covered entities during the preceding calendar year. The Secretary of the Treasury will calculate the amount for each covered entity's fee. Such fees will be transferred to the Federal Supplementary Medical Insurance Trust Fund (Medicare Part B).

In this section branded prescription drug sales refer to such drugs sold to any specified government program (Medicare Parts B and D, Medicaid, any program under which branded prescription drugs are purchased by the Departments of Veterans Affairs and Defense, and the TRICARE retail pharmacy program) or through coverage under any such program. The Secretaries responsible for any specified government program will annually report the total branded prescription drug sales for each covered entity to the Secretary of the Treasury.

*(This section is modified in section 1404 of the Reconciliation Act)*

**Section 9009. Imposition of Annual Fee on Medical Device Manufacturers and Importers**

*(This section is repealed in section 1405 of the Reconciliation Act)*

**Section 9010. Imposition of Annual Fee on Health Insurance Providers**

Each covered entity that provides health insurance will pay an annual fee. *Each entity will pay a ratio relative to such entity's net premiums, third party administration agreement fees and the aggregate net premiums and third party administration fees of all covered entities during the preceding calendar year.* The Secretary of the Treasury will calculate each covered entity's fee.

A covered entity is any entity that provides health insurance in the United States with exemptions for any employer that self-insures its employees and any governmental entity. Each covered entity will report net premiums and third party administration agreement fees to the Secretary of the Treasury. Failure to report this information will result in a penalty of at least $10,000.

*(This section is modified in Section 10905)*

**Section 9011. Study and Report of Effect on Veterans Health Care**

The Secretary of Veterans Affairs will conduct a study on the effect (if any) of the provisions of sections 9008, 9009, and 9010 on the cost of medical care provided to veterans and veterans' access to medical devices and branded prescription drugs. The Secretary of Veterans Affairs will report study results to Congress by December 31, 2012.

**Section 9012. Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy**

This section amends the Internal Revenue Code to eliminate the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

**Section 9013. Modification of Itemized Deduction for Medical Expenses**

This section modifies the Internal Revenue Code to increase the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals over age 65 will be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016. These amendments are effective for taxable years beginning after 2012.

**Section 9014. Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers**

This section amends the Internal Revenue Code to limit the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider’s gross income from health business is derived from insurance plans that meet minimum essential coverage requirements. The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other s who work on behalf of a covered health insurance provider.

**Section 9015. Additional Hospital Insurance Tax on High-Income Taxpayers**

This section amends the Internal Revenue Code to increase the hospital tax rate by *0.5 percentage points* on an individual taxpayer earning over $200,000 or $250,000 for married couples filing jointly applicable to any taxable year beginning after December 31, 2012.

*(This section is modified in section 10906)*

**Section 9016. Modification of Section 833 Treatment of Certain Health Organizations**

An organization cannot be considered a Blue Cross and Blue Shield organization for the purposes of tax treatment unless 85 percent or more of the organization's total premium revenue is used for clinical services on its enrollees.

**Section 9017. Excise Tax on Elective Cosmetic Medical Procedures**

*(This section is made null and void in section 10907)*

## Subtitle B - Other Provisions

**Section 9021. Exclusion of Health Benefits Provided by Indian Tribal Governments**

Gross income does not include the value of any qualified Indian health care benefit. This includes any health service or benefit, medical care, or coverage provided by the Indian Health Service, an Indian tribe or tribal organization. This section applies to benefits and coverage provided after the date of enactment of this Act.

**Section 9022. Establishment of Simple Cafeteria Plans for Small Businesses**

This section amends the Internal Revenue Code to allow for simple cafeteria plans for small businesses to be established. A simple cafeteria plan is a plan:

- Established and maintained by an eligible employer;
- The employer is required to make a contribution to provide qualified benefits on behalf of each qualified employee; and
- All employees who had at least 1,000 hours of service are eligible to participate.

The rate of compensation in relation to salary reduction contributions cannot be greater for highly compensated employees than an employee who is not highly compensated. Employers may exclude employees who are not yet 21, who have worked for the employer for less than a year, or who are covered under a collective bargaining agreement. An eligible employer will have an average of less than 100 employees for either of the 2 preceding years. Amendments in this section will apply to years beginning after December 31, 2010.

**Section 9023. Qualifying Therapeutic Discovery Project Credit**

This section amends the Internal Revenue Code to establish a qualifying therapeutic discovery project credit for any taxable year that is equal to 50 percent of the qualified investment made by an eligible taxpayer. Qualified investments are the aggregate amount of costs paid or incurred for necessary expenses related to a qualifying therapeutic discovery project, which does not include remuneration for an employee, interest expenses, or facility maintenance.

A qualifying therapeutic discovery project is a project designed to:

- Treat or prevent diseases through clinical trials;
- Diagnose diseases or conditions by developing molecular diagnostics to guide therapeutic decisions; or
- Develop a product, process, or technology to further the delivery or administration of therapeutics.

An eligible taxpayer is a taxpayer that employs no more than 250 employees.

Within 60 days of enactment of this Act, the Secretary of the Treasury will establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits. The total amount of credits will not exceed $1 billion for the 2-year period. The

Secretary of the Treasury will distribute the credit in the form of a grant, which will not be considered a part of the recipient's taxable income. Non-taxpayers (Federal, State, or local governments; any organizations defined in section 501(c) of the Internal Revenue Code; any entity defined in Section 54(j) of such Code; or any partnership of the aforementioned groups) are not eligible for grants.

There is appropriated such sums as may be necessary to carry out this section. Grant applications must be received by January 1, 2013 in order to be awarded.

# Title X - Strengthening Quality, Affordable Health Care for All Americans

## Subtitle A - Provisions Relating to Title I

### Section 10101. Amendments to Subtitle A

*The following 9 paragraphs modify section 1001 of this Act.*

A group health plan and a health insurance issuer offering group or individual coverage may not establish lifetime limits or annual limits on the dollar value of benefits for any participant.

In plan years beginning before January 1, 2014, a group health plan or health insurance issuer may only establish a restricted annual limit on the dollar value for any participant with respect to the scope of essential health benefits under section 1302. Additionally, annual or lifetime limits may be placed on specific covered benefits that are not essential benefits under section 1302.

A group plan or insurance coverage offered outside the Exchange will disclose to the Secretary and the State insurance commissioner and make available to the public: claims payment policies and practices; data on enrollment; data on the number of denied claims; data on rating practices; and information on cost-sharing and payments for out-of-network coverage.

A group health plan (other than a self-insured plan) is prohibited from discriminating in favor of highly compensated individuals.

Wellness and health prevention programs may not require the disclosure of any information related to the lawful presence, use, storage, ownership, or possession of a firearm or ammunition. Premiums may not be increased, coverage may not be denied, and a discount, rebate or reward for participation in a wellness program may not be reduced on the basis of the lawful use, storage, ownership, or possession of a firearm or ammunition.

Insurance issuer reporting requirements are modified to be a report on the ration of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. The report will not include Federal taxes and licensing or regulatory fees.

Beginning no later than January 1, 2011, a health insurance issuer offering group of individual coverage (including a grandfathered health plan) will provide an annual rebate to each enrollee on a pro rata basis if the amount of premiums spent on clinical costs or for activities that improve health care quality is less

than 85 percent in the large group market, 80 percent in the small group or individual market, or such higher percentage set by State regulation for each market.

A group health plan and a health insurance issuer offering group or individual coverage will:

- Comply with the applicable State external review process for such plans; or
- Implement an external review process that meets standards established by the Secretary if the State has not established a process or if the plan is a self-insured plan not subject to State insurance regulation.

If a group health plan or health insurance issuer offering group or individual coverage:

- Requires an enrollee to designate a primary care provider, it will allow them to designate any participating primary care provider who can accept the individual;
- Covers any benefits related to services in an emergency department, it must do so without requiring prior authorization or requiring that the provider be a participating provider;
- Requires an enrollee to designate a primary care provider for a covered child, it will allow the enrollee to designate a physician in the plan network who specialized in pediatrics; or
- Provides coverage for obstetrics or gynecological care, it may not require authorization or referral for a female enrollee or beneficiary who seeks coverage for such care by a health professional specializing in obstetrics or gynecology.

*The following paragraph modifies section 1003 of this Act.*

Grant will also be awarded to establish medical reimbursement data centers to collect, analyze, and organize medical reimbursement information from health insurance issuers; make such information available to issuers, health care providers, researchers, policymakers, and the general public; and develop fee schedules and other database tools that reflect market rates for medical services and geographic differences in rates.

**Section 10102. Amendments to Subtitle B**

*The following paragraph modifies section 1103 of this Act.*

The website established for providing ways for residents of any State to access certain coverage options will include coverage with the small group market for small businesses and their employees, including reinsurance, tax credits, and other information specifically regarding affordable health care options for small businesses.

**Section 10103. Amendments to Subtitle C**

*The following paragraph modifies section 1201 of this Act.*

If a group health plan or health insurance issuer offering group or individual coverage provides coverage to qualified individual, than the plan or issuer:

- May not deny the individual participation in a clinical trial;
- May not deny (or limit) the coverage of routine patient costs for services provided (consistent with the coverage provided in the plan) in connection with participation in the trial; and
- May not discriminate against the individual on the basis of participating in such trial.

*The following paragraph modifies section 1251 of this Act.*

Provisions of Sections 2715 (developing and using uniform explanation of coverage documents) and 2718 (reporting premium revenues and providing enrollees rebates) of the Public Health Act will apply to grandfathered health plans for plan years beginning after the date of enactment of this Act.

*The following sections are added to Subtitle C of Title I of this Act:*

*Section 1253. Annual Report on Self-Insured Plans*

The Secretary of Labor will prepare an aggregate annual report within 1 year of the enactment of this Act, which will include general information on self-insured group health plans and data from the financial filings of self-insured employers. This report will be submitted to Congress.

*Section 1254. Study of Large Group Market*

The Secretary will conduct a study of the fully-insured and self-insured group health plan markets to: compare the characteristics of employers, health plan benefits, financial solvency, capital reserve levels and the risk of becoming insolvent; and determine the extent to which new market reforms are likely to cause adverse selection in the large group market or encourage small and midsize employers to self-insure.

The Secretary will, in coordination with the Secretary of Labor, collect information and analyze:

- The extent to which self-insured plans can offer less costly coverage and, if so, whether lower costs are due to efficient administration or denial of claims and limited benefits packages;
- Claim denial rates, plan benefit fluctuations, and the impact of limited recourse options on consumers; and
- Any potential conflict of interest within these plans.

This report will be submitted to Congress within 1 year of the enactment of this Act.

**Section 10104. Amendments to Subtitle D**

*The following paragraph modifies section 1301 of this Act.*

Any reference in this title to a qualified health plan will include a qualified health plan offered through the CO-OP program (section 1322) and a multi-state plan (section 1334). The Secretary will permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria and services are coordinated with the entity offering the qualified health plan. Additionally, a qualified health plan may vary premiums by rating (as defined in section 2701 of the Public Service Act) as appropriate.

*The following paragraph modifies section 1302 of this Act.*

If any item or service covered by a qualified health plan is provided by an FQHC, the plan issuer will pay at least the amount that would have been paid under Medicaid.

*The following 4 paragraphs amend section 1303 of this Act.*

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law. A State may repeal this law and allow such services to in the Exchange.

If a qualified health plan provides coverage of abortions for which public funding is prohibited, the issuer of the plan will not use any of the credit under section 36B of the Internal Revenue Code or any cost-sharing reduction under section 1412 of this Act. The plan issuer will collect from each enrollee a separate payment, to be deposited in separate allocation accounts, for:

- An amount equal to the portion of premium to be paid directly by the enrollee for coverage of services other than abortion services; and
- The actuarial value of the coverage for such services.

The plan issuer must establish allocation accounts to segregate premium payments and payments to cover the cost of abortion services. The actuarial value cost may not be estimated at less than $1 per enrollee, per month. State health insurance commissioners will ensure that health plans comply with these segregation requirements.

A qualified health plan, which provides coverage of abortions for which public funding is prohibited, will provide notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment. No qualified health plan offered through an exchange may discriminate against any individual health care provider of facility because of its unwillingness to provide, pay for, provide coverage or, or refer for abortions.

*The following 3 paragraphs amend section 1311 of this Act.*

The Exchange will require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public the following in plain language:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment, number of claims denied, and rating practices; and
- Information on cost-sharing and payments for out-of-network coverage.

The Exchange will require these health plans seeking certification as qualified health plans to permit individuals to learn about cost-sharing for a specific item or service in a timely manner. The Secretary of Labor will incorporate these rules for group health plans.

Strategies that may be used to reward quality through market-based incentives include implementing activities to reduce health and health care disparities, including language services, community outreach, and cultural competency training.

*The following paragraph modifies the False Claims Act (Section 3730(e) of Title 31, U.S. Code).*

The court will dismiss an action or claim under this section, unless opposed by the Government, if the allegations or transactions alleged in the action or claim were publicly disclosed:

- In a Federal criminal, civil, or administrative hearing in which the Government is a party;
- In a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

- From the news media.

*The following paragraph amends section 1313 of this Act.*

The GAO study of Exchange activities will include a survey of the cost and affordability of health insurance in the Exchange for owners and employees of small business concerns.

*The following paragraph amends section 1313 of this Act.*

By July1, 2013, the Secretary will publish regulations regarding the repayment of loans and grants under the CO-OP program. Loans will be repaid within 5 years and grants will be repaid within 15 years.

*Section 1323 of this act is voided.* [Removes the community health insurance option]

*The following paragraph modifies section 1324.*

Any health insurance coverage offered by a private issuer is subject to the same laws that apply to qualified health plans offered by a multi-State qualified health plan (section 1334).

*The following 2 paragraphs modify section 1331.*

The amount of payment to a State establishing an alternative program will be 95 percent of the premium tax credit and cost-sharing reductions that would have been provided to individuals in standard health plans in the State through an Exchange.

An eligible individual for a State alternative program will include an alien lawfully present in the United States, whose income is less than 133 percent of the poverty line.

*Section 1333 of this Act is amended by striking Subsection (b).* [Removes the nationwide qualified health plan]

*The following section is added to Part IV of Subtitle D of Title I of this Act:*

*Section 1334. Multi-State Plans*

The Director of the Office of Personnel Management will enter into contracts with insurance issuers, without regard to competitive bidding requirements, to offer at least 2 multi-State qualified health plans through each Exchange in each State. At least one contract should be with a nonprofit entity. Provisions of these contracts will be similar to those with carriers under the Federal Employees Health Benefit Program (FEHBP). The Director will ensure that at least one of these programs does not offer coverage of abortion services for which public funding is prohibited.

A health insurance issuer is eligible to enter into such a contract if it agrees to offer a plan that meets requirements in each Exchange in each State, is licensed in each State, and complies with minimum standards.

A multi-State qualified health plan must meet the following requirements:
- Offers a uniform benefits package in each state that consists of essential benefits;
- Meets all requirements of this title with respect to a qualified health plan;

- Provides for determination of premiums on the basis of rating requirements of the Public Health Service Act; and
- The issuer offers the plan in all geographic regions and in all States that have adopted community ratings before the date of enactment of this Act.

Nothing in this section will preclude a State from requiring additional benefits be covered in such State.

An individual enrolled in a multi-State qualified health plan will be eligible for premium tax credits and cost-sharing assistance in the same manner as an individual enrolled in a qualified health plan.
In a State with age rating requirements lower than 3:1, the State may require Exchanges in such State only permit multi-State qualified health plans that comply with the State's more protective rating requirement.

The Director will make contracts for multi-State qualified health plan such that in the first year the issuer offers the plan in at least 60 percent of States, in 70 percent of States in the second year, in 85 percent of States in the third year, and in all States in each subsequent year.

The Director may establish separate units of offices within the Office of Personnel Management to ensure multi-State qualified health plans are administered separate from and do not interfere with the effective administration of the FEHBP. The Director will establish an Advisory Board to make recommendations on the multi-State plans. There are appropriated such sums as may be necessary to carry out this section.

**Section 10105. Amendments to Subtitle E**

*The following paragraph amends section 1421 of this Act.*

The dollar amount used for calculating the tax credit for a small business is $25,000 for taxable years 2010 through 2013. In subsequent years the dollar amount is $25,000 multiplied by the cost-of-living adjustment for the calendar year.

*The following section is added to Part I of Subtitle E of Title I of this Act:*

*Section 1416. Study of Geographic Variation in Application of FPL*

The Secretary will conduct a study to examine the feasibility and implication of adjusting the application of the federal poverty level under this subtitle for different geographic regions in order to reflect the variations in cost-of-living in different areas. The study should include a methodology to make such an adjustment. By January 1, 2013, the Secretary will submit a report with recommendations to Congress.

**Section 10106. Amendments to Subtitle F**

*The following 4 paragraphs amend section 1501 of this Act.*

Congress makes the following findings regarding the individual responsibility requirement:
- Without the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers;
- The economy loses $207 billion a year because of poorer health and shorter lifespan of the uninsured. By significantly reducing the number of uninsured, this economic cost will be reduced;

- By reducing the number of uninsured, health insurance premiums will be lowered through reduced cost-shift;
- 62 percent of all personal bankruptcies are caused in part by medical expenses. By increasing insurance coverage, families will have improved financial security; and
- The Government has a significant role in regulating health insurance under several Acts. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

The penalty on any taxpayer for a taxable year will be the lesser of:
- The sum of monthly penalty amounts for months during which 1 or more failures occurred; or
- An amount equal to the national average premium of a qualified health plan at the bronze level for the applicable family size.

The monthly premium amount is equal to 1/12 of the greater of a flat dollar amount or percentage of income. A flat dollar amount is equal to the lesser of:
- The sum of the applicable dollar amounts for all individuals with a failure during the month; or
- 300 percent of the applicable dollar amount (without regard for the special rule for individuals under age 18).

The percentage of income is an amount equal to the following percentage of the taxpayer's household income for the taxable year: *1 percent* for taxable years beginning in 2014; *2 percent* for taxable years beginning in 2015; and *2.5 percent* for taxable years beginning after 2015. *The applicable dollar amount is $325 in 2015.*

*(This section is modified in section 1002 of the Reconciliation Act)*

**Section 10107. Amendments to Subtitle G**

Section 1562 of this Act is renumbered.

*The following sections are added to Subtitle G of Title I of this Act:*

*Section 1562. GAO Study Regarding the Rate of Denial of Coverage and Enrollment by Health Insurance Issuers and Group Health Plans*

The Comptroller General will conduct a study on the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans by group health plans and health insurance issuers. Data collection will include: reasons coverage was denied and reasons applications are denied. Within a year of enactment of this Act, the Comptroller General will submit a report which will be made available to the public.

*Section 1563. Small Business Procurement*

Part 19 of the Federal Acquisition Regulation, Section 15 of the Small Business Act and any other applicable laws or regulations establishing procurement requirements for small business concerns may not be waived in any contract awarded under this Act.

**Section 10108. Free Choice Vouchers**

An employer that offers minimum essential coverage to its employees and pays any portion of costs of such plan will provide free choice vouchers to each qualified employee. A qualified employee is one:

- Whose required contribution for minimum essential coverage is 8 to 9.8 percent of the employee's household income for the taxable year;
- With a household income less than 400 percent of the federal poverty level; and
- Who does not participate in a health plan offered by the employer.

The amount of any free choice voucher will be equal to the monthly portion of the cost that would have been paid by the employer if the employee was covered by the employer-sponsored plan. Vouchers will be used by employees as credits in an Exchange, and the employer will pay any amounts credited to the Exchange. If the voucher amount exceeds the monthly premium, the excess will be paid to the employee.

The Internal Revenue Code is amended to say gross income will not include the amount of any free choice voucher provided by an employer under this Act. This is effective after December 31, 2013. The amount of the voucher issued to each employee may be tax deductable for the employer.

Individuals that receive a free choice voucher will not be eligible for the premium assistance credit. Employers that provide a voucher will not be assessed a penalty for employees that qualify for premium tax credits or cost-sharing reductions.

**Section 10109. Development of Standards for Financial and Administrative Transactions**

*The following 3 paragraphs amend section 1173 of the Social Security Act (which was amended by section 1104 of this Act).*

The Secretary will solicit input from standard setting organizations and stakeholders by January 1, 2012, and every 3 years on:

- If there can be greater uniformity in financial and administrative activities and items; and
- If such activities should be considered financial and administrative transactions.

By January 1, 2012, the Secretary will seek input on activities and items relating to:

- If the application process for enrollment of health care providers can be made electronic and standardized;
- If the standards and operating rules in section 1173 should apply to other health care transactions;
- If there could be more transparency and consistency regarding claim edits used by health plans; and
- If health plans should be required to publish their timeliness of payment rules.

The International Classification of Diseases, Ninth edition, Clinical Modification (ICD-9-CM) Coordination and Maintenance Committee will hold a meeting to get stakeholder input on revising the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9 and ICD-10) and make recommendations for revisions. The Secretary will make appropriate revisions and post any revised crosswalk on the website of CMS.

## Subtitle B - Provisions Relating to Title II

### Part I - Medicaid and CHIP

**Section 10201. Amendments to the Social Security Act and Title II of this Act**

*The following paragraph modifies section 2004 of this Act.*

Individuals will qualify for Medicaid who are under age 26, are not eligible for Medicaid for other reasons, were in foster care at age 18 or an older age set by the State, and were enrolled in Medicaid while in foster care. The effective date for this is January 1, 2014.

*The following 3 paragraphs amend section 1905 of the Social Security Act as amended by section 2001 of this Act.*

During the period of January 1, 2014 through September 30, 2019, the FMAP will be increased by 2.2 percentage points for any State that:

- Is an expansion state;
- The Secretary determines will not receive any payments due to increased FMAP for newly eligible individuals; and
- Has not been approved to divert a portion of the State DSH allotment to the costs of providing medical assistance.

For the period *2014 through 2018*, the formula for calculating FMAP *will be modified for expansion States, such that the State share of the cost for providing coverage for non-pregnant childless adults will be reduced by 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, and 90 percent in 2018*.

For a State that requires political subdivisions to contribute towards the non-Federal share of expenditures required under Medicaid, the State will not be eligible for an increase in the FMAP if the subdivisions are required to pay a greater percentage of the expenditures than would have been required on December 31, 2009.

*(This section is modified in section 1201 of the Reconciliation Act)*

*The following 3 paragraphs modify section 2551 of this Act.*

The DSH allotment for Hawaii for the second, third, and fourth quarters of fiscal year 2012 will be $7.5 million. In 2013 and each subsequent fiscal year the DSH allotment for Hawaii will be increased in the same manner as allotments for low DSH States are increased.

The Secretary may not impose a limit on the total amount of payments made to hospitals under the QUEST Demonstration Project except to ensure they do not receive excessive payments.

Reductions in DSH allotments will be based on whether a State has spent most of its DSH allotment for the period 2004 through 2008. States that have spent 99.9 percent or more of the allotment will have smaller reductions. Applicable percentages for low DSH States range from 17.5 to 25 percent and for all other States 35 to 50 percent. After 2012, the applicable percentage will be:

- In a low DSH State that has not spent 99.9 percent of the DSH allotment- Percentage reduction in uninsured from previous fiscal year times 27.5 percent;

- In a low DSH State that has spent 99.9 percent or more of the DSH allotment- Percentage reduction in uninsured from previous fiscal year times 20 percent;
- For all other States that have not spent 99.9 percent of the DSH allotment- Percentage reduction in uninsured from previous fiscal year times 55 percent; or
- For all other States that have spent 99.9 percent or more of the DSH allotment - Percentage reduction in uninsured from previous fiscal year times 40 percent.

*The following paragraph modifies section 2101 of this Act.*

Low-income children eligible for CHIP but enrolled through an Exchange due to an insufficient allotment will be eligible for premium assistance credits and cost-sharing reductions.

*The following paragraph amends section 1115 of the Social Security Act*

The Secretary will issue regulations relating to applications for, and renewals of, demonstration projects that would have an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under Medicaid or CHIP.

*The following section is added to Subtitle F of Title III of this Act.*

*Section 3512. GAO Study and Report on Causes of Action*

The Comptroller General will conduct a study on whether the development, recognition, or implementation of any guideline or other standards of certain sections of this Act would result in the establishment of a new cause of action or claim. Within 2 years of the enactment of this Act, the Comptroller General will submit findings to Congress.

**Section 10202. Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes**

A balancing incentive payment State that meets criteria will receive an increased FMAP for eligible medical assistance expenditures. Such a State will submit an application and have less than 50 percent of total Medicaid expenditures for long-term care made for non-institutionally-based services and supports.

Participating States must meet target spending percentages for total Medicaid expenditures for long-term care services on home and community-based services of 25 or 50 percent by October 1, 2015. The State will use additional funds to provide new or expanded offerings of non-institutionally-based long-term care services. Within 6 months of applying, the State agrees to:

- Develop a statewide system to enable consumers to access all long-term services and supports;
- Conflict-free case management services to coordinate care and support the beneficiary; and
- Develop core standardized assessment instruments for determining eligibility for non-institutionally-based long-term care services and supports.

The State will also collect data from service providers and on a set of core quality and outcome measures selected by the Secretary.

The FMAP for participating States will be increased by 2 to 5 percentage points. The aggregate amount of payments made to balancing incentive States under this section will not exceed $3 billion. The balancing incentive period is October 1, 2011 through September 30, 2015.

**Section 10203. Extension of Funding for CHIP through Fiscal Year 2015 and Other CHIP-Related Provisions**

This section contains technical amendments related to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

*The following paragraph amends section 2101 of this Act.*

The enhanced FMAP for CHIP will begin in 2015 not 2013. The State will establish procedures to ensure (when the allotment for CHIP is insufficient) children who are screened and found not to be eligible for Medicaid are enrolled in a qualified health plan offered through an Exchange that has been certified that it offers child health coverage with cost-sharing similar to the State child health plan.

*The following 2 paragraphs amend section 2104 of the Social Security Act (amended by section 2101 of this Act).*

There is appropriated the following amounts to carry out CHIP: $17.4 billion for fiscal year 2013, $19.1 billion for 2014, and for 2015 two allotments totaling $5.7 billion.

For fiscal year 2013 and 2014, State allotments for CHIP will be adjusted by an allotment increase factor. CHIP will be funded through 2015.

*The following paragraph amends section 2110 of the Social Security Act is amended.*

Children of employees of a public agency in a State may be considered a targeted low-income child for CHIP if a maintenance of effort for family coverage is met or there is a determination of financial hardship.

*The following paragraph amends section 2113 of the Social Security Act.*

Grants for outreach and enrollment efforts for CHIP will be available through 2015. Appropriations to carry this out will be increased by $40 million.

*The following paragraph amends section 108 of CHIPRA.*

A one-time appropriation of $15.4 billion will accompany one of the semi-annual allotments for fiscal year 2015 and remain available until expended.

**Part II - Support for Pregnant and Parenting Teens and Women**

**Section 10211. Definitions**

Accompaniment: assisting, representing, and accompanying a women in seeking judicial relief for child support, child custody, restraining orders, and in filing criminal charges.

Intervention services: with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour hotline services for police protection and referral to shelters.

Supportive Social Services: transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

**Section 10212. Establishment of Pregnancy Assistance Fund**

The Secretary will establish a Pregnancy Assistance Fund to award competitive grants to States to assist pregnant and parenting teens and women.

**Section 10213. Permissible Uses of Fund**

A State may use grant funds for eligible institutions of higher education to establish, maintain, or operate pregnant and parenting student services. Funds will not supplant existing funding for such services and eligible institutions must match with non-Federal funds an amount equal to 25 percent of the funding provided. An eligible institution must submit a report to the State each year it receives funding. Programs and activities that may be supported with this funding include:

- Conduct a needs assessment on campus and within the local community;
- Annually assess how the eligible institution meets the needs of students who are pregnant or parents;
- Identify public and private service providers that are qualified to meet needs;
- Assist pregnant and parenting students, fathers or spouses in locating and obtaining services; and
- Provide referrals for prenatal care and delivery, foster care, or adoption as requested by a student.

A State may use grant funds to eligible high schools and community service centers to establish, maintain, or operate pregnant and parenting services in the same manner as above. A State may use grant funds to its State Attorney General to assist statewide offices in providing:

- Intervention services, accompaniment, and supportive social services for eligible women who are victims of domestic violence, sexual violence, sexual assault, or stalking; and
- Technical assistance and training relating to violence against eligible pregnant women.

A State may use grant funds to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part.

**Section 10214. Appropriations**

There is appropriated $25 million for each of fiscal years 2010 through 2019 to carry out this part.

**Part III - Indian Health Care Improvement**

**Section 10221. Indian Health Care Improvement**

The Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S.1790) which revises and extends the Indian Health Care Improvement Act is enacted into law. This includes the authorization of such sums as needed to carry out this Act in fiscal year 2010 and each fiscal year thereafter.

*The following 2 paragraphs amend the Indian Health Care Improvement Act.*

The Secretary may establish a national Community Health Aide program. An Indian tribe or tribal organization may elect to use dental health aide therapist services or midlevel dental health provider services authorized under State law.

Any limitation by other Federal laws on the use of Federal funds appropriated to the Indian Health Service will apply with respect to the coverage of abortions.

## Subtitle C - Provisions Relating to Title III

### Section 10301. Plans for a Value-Based Purchasing Program for Ambulatory Surgical Centers

*The following paragraph amends section 3006 of this Act.*

The Secretary will develop a plan for implementing a value-based purchasing program for payments under Medicare for ambulatory surgical centers, in consultation with relevant affected parties and submit it to Congress by January 1, 2011.

### Section 10303. Development of Outcome Measures

*The following paragraph amends section 3011 of this Act.*

The Secretary will develop and periodically update provider-level outcome measures for hospitals and physicians. The Secretary will develop at least 10 outcome measures for acute and chronic diseases within 2 years and for primary and preventive care within 3 years.

*The following paragraph amends section 3013 of this Act.*

The Secretary will publicly report on measures for hospital-acquired conditions to the extent practicable.

### Section 10304. Selection of Efficiency Measures

Section 3014 is amended to include quality and efficiency measures.

### Section 10305. Data Collection; Public Reporting

*The following paragraph amends section 3013 of this Act.*

The Secretary will establish and implement an overall strategic framework to carry out the public reporting of performance information summarizing data on quality measures.

### Section 10306. Improvements under the Center for Medicare and Medicaid Innovation

*The following 2 paragraphs amend section 3021 of this Act.*

The Secretary may elect to limit testing of payment and service delivery models to certain geographic areas. Additional models may include: using telehealth services to treat behavioral health and stroke and improve capacity of providers to treat chronic complex conditions; or using a diverse network of provider to improve care coordination for individuals with 2 or more chronic conditions.

When making a determination about expanding models or demonstration projects, the Secretary will focus on those that improve the quality of patient care and reduce spending.

**Section 10307. Improvements to the Medicare Shared Savings Program**

*The following paragraph amends section 3022 of this Act.*

The Secretary may use any of the payment models described in this section for the shared savings program. This includes a partial capitation model, which is a mix of fee-for-service payments and a fixed amount per patient.

**Section 10308. Revisions to National Pilot Program on Payment Bundling**

*The following paragraph amends section 3023 of this Act.*

The Secretary may expand the duration and scope of any pilot program t any point after January 1, 2016, if CMS certifies expansion would reduce Medicare spending and a determination is made that benefits would not be denied or limited. A separate pilot program will be conducted to test the continuing care hospital model.

**Section 10309. Revisions to Hospital Readmissions Reduction Program**

*The following paragraph amends section 3025 of this Act.*

The Secretary will make payments (in addition to the base operating DRG) that are equal to the product of the base operating DRG and the adjustment factor for the hospital for the fiscal year.

**Section 10310. Repeal of Physician Payment Update**

*Section 3101 of this Act is repealed.*

**Section 10312. Certain Payment Rules for Long-Term Care Hospital Services and Moratorium on the Establishment of Certain Hospitals and Facilities**

This section amends section 3106 to extend these rules and moratorium for an additional year.

**Section 10313. Revisions to the Extension for the Rural Community Hospital Demonstration Program**

*The following paragraph amends section 3123 of this Act.*

The Secretary may conduct the demonstration program for an additional 5 year period.

**Section 10315. Revisions to Home Health Care Provisions**

*The following 3 paragraphs amend section 3131 of this Act.*

The payment adjustments for home health care services will begin in 2014.

The Secretary will conduct a study on home health agencies costs for providing ongoing access to low-income Medicare beneficiaries or those in medically underserved areas, and treating beneficiaries with varying severity levels of illness, with a report submitted to Congress by March 1, 2014.

The Secretary may conduct a demonstration project based on the results of the study. A total of $500 million will be made available for fiscal years 2015 through 2018 for the study and demonstration project.

**Section 10316. Medicare DSH**

*The following paragraph amends section 3133 of this Act.*

Factor two is: 1 – (Percent uninsured in 2013 – Percent uninsured based on most recent data).

*In fiscal years 2018 and 2019, factor two is: 1 – (Percent uninsured in 2013 – Percent uninsured based on most recent data – 0.2 percent).*

*(This section is modified in section 1104 of the Reconciliation Act)*

**Section 10317. Revisions to Extension of Section 508 Hospital Provisions**

*The following 2 paragraphs amend section 3137 of this Act.*

For the implementation of this extension in fiscal year 2010, the Secretary will use the hospital wage index published in the Federal Register on August 27, 2009 and any subsequent corrections.

A Subsection (d) hospital may qualify for an additional payment that reflects the difference between the wage indexes for the following periods: October 2009 through March 2010 and April 2010 through September 2010.

**Section 10319. Revisions to Market Basket Adjustments**

This section further modifies to the market basket updates in section 3401 for inpatient hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, psychiatric hospitals, hospice care, and outpatient hospital services.

**Section 10320. Expansion of the Scope of the Independent Medicare Advisory Board**

*The following 5 paragraphs amend section 3403 of this Act.*

In any year the Board is not required to submit a proposal, the Board will submit an advisory report on Medicare-related matters to Congress.

The Board will consider data and findings in the annual reports prepared by the Board when developing each proposal, in addition to the other specified criteria.

Annually (beginning July 1, 2014), the Board will produce a report with standardized information on system-wide health care costs, patient access to care, use, and quality of care that allows for comparison by region, types of services, types of providers, and both private payers and Medicare. Each report will include information on:

- The quality and costs of care for the population at the most local level determined practical;
- Beneficiary and consumer access to care, patient and caregiver experience of care, and cost-sharing or out-of-pocket burden on patients;
- Epidemiological shifts and demographic changes; and
- The proliferation, effectiveness, and use of health care technologies.

By January 15, 2015, and at least every 2 years, the Board will submit recommendation to slow of the growth in national health expenditures (excluding Medicare and other Federal health care programs) to Congress and the President.

The Independent Medicare Advisory Board is renamed the Independent Payment Advisory Board.

**Section 10322. Quality Reporting for Psychiatric Hospitals**

*The following paragraph amends section 3401 of this Act.*

A psychiatric hospital or psychiatric unit that fails to submit data on quality measures for rate year 2014 and each subsequent year to the Secretary will have payments reduced for that year. By October 1, 2012, the Secretary will publish the measures to be applicable in 2014. Quality data will be made available to the public.

**Section 10323. Medicare Coverage for Individuals Exposed to Environmental Hazards**

*The following 4 paragraphs amend Title XVIII of the Social Security Act.*

Individuals determined to have been affected by certain environmental exposure will be deemed eligible for Medicare Parts A and B. The Commissioner of Social Security, in consultation with the Secretary, will determine if people are environmental exposure affected individuals.

An environmental exposure affected individuals is any individual who:

- Is diagnosed with 1 or more of the following conditions:
  - Asbestosis, pleural thickening, or pleural plaques; or
  - Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary;
- Has been present for an aggregate 6 months in the geographic area subject to an emergency declaration during a period not less than 10 year prior to such diagnosis and prior to the remedial and removal actions being implemented;
- Files an application for benefits under this title; and
- Is determined under this section to meet criteria.

An environmental exposure affected individual may also be any individual who:

- Is diagnosed with a medical condition caused by the exposure to a public health hazard to which an emergency declaration applies;
- Has been present for an aggregate 6 months in the geographic area subject to the emergency declaration involved;
- Files an application for benefits under this title; and
- Is determined under this section to meet criteria.

The Secretary will establish a pilot program to provide innovation approaches to furnishing comprehensive, coordinated, and cost-effective care to environmental exposure affected individuals with Medicare Part B. The Secretary may establish a separate pilot project for each geographic area subject to an emergency declaration. Such sums as determined necessary will be allocated to carry out these pilot programs.

*The following paragraph amends section 5507 of this Act.*

The Secretary will establish a program to make competitive grants to eligible entities to screen at-risk individuals for environmental health conditions and develop and disseminate public information and education on: available screenings; the detection, prevention and treatment of environmental health conditions; and the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions (as defined in section 1881A of the Social Security Act). There is appropriated $23 million for the period fiscal year 2010 through 2014 and $20 million for 5-fiscal year period thereafter.

**Section 10324. Protections for Frontier States**

This section sets a minimum area wage index of 1.00 for hospitals located in frontier States in section 1886 of the Social Security Act. This does not apply to any hospital in a State that receives a non-labor related share adjustment (Alaska and Hawaii).

*The following paragraph amends section 3138 of this Act.*

For services provided on or after January 1, 2011, the area wage adjustment factor for any hospital outpatient department located in a frontier State will not be less than 1.00.This does not apply to any hospital outpatient department in a State that receives a non-labor related share adjustment (Alaska and Hawaii).

*The following paragraph amends section 3102 of this Act.*

For physician services provided in a frontier State on or after January 1, 2011, the practice expense index will increased to be at least 1.00. This does not apply to services provided in a State that receives a non-labor related share adjustment (Alaska and Hawaii).

**Section 10325. Revision to Skilled Nursing Facility Prospective Payment System**

Version 4 of the Resource Utilization Groups (RUG-IV) will not be implemented before October 1, 2011. Beginning October 1, 2010, the Secretary will implement the change specific to therapy provided on a concurrent basis that is part of RUG-IV and changes to the lookback period.

**Section 10326. Pilot Testing Pay-For-Performance Programs for Certain Medicare Providers**

By January 1, 2016, the Secretary will conduct separate pilot programs to test the implementation of a value-based purchasing program for payments under Medicare for: psychiatric hospitals and psychiatric units, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs. Spending on these pilot programs must be within the expected budget of each provider in a year without such a program. After January 1, 2018, the Secretary may elect to expand these pilot programs.

**Section 10327. Improvements to the Physician Quality Reporting System**

*The following 2 paragraphs amend section 1848 of the Social Security Act.*

For 2011 through 2014, incentive payments for quality reporting by eligible professionals will be increased by 0.5 percentage points if they meet criteria, which include submitting data on quality measures and participating in a Maintenance of Certification program.

The Medicare Advantage Regional Plan Stabilization Fund is eliminated and any remaining funds will be transferred to the Federal Supplementary Medical Insurance Trust Fund.

**Section 10328. Improvement in Part D Medication Therapy Management (MTM) Programs**

*The following paragraph amends section 1860D-4 of the Social Security Act.*

For plan years beginning after March 23, 2012, prescription drug plan sponsors will offer medication therapy management (MTM) services to targeted Medicare beneficiaries, including an annual comprehensive medication review and follow-up interventions as needed. The prescription drug plan sponsor will have a process to assess the medication use of at risk individuals not enrolled in the MTM program. Targeted beneficiaries will be automatically enrolled and have the option to opt-out.

**Section 10329. Developing Methodology to Assess Health Plan Value**

The Secretary will develop, in consultation with relevant stakeholders, a methodology to measure health plan value that takes into account: the overall cost to enrollees, the quality of care provided, the efficiency of the plan, the relative risk of the plan's enrollees compared to other plans, the actuarial value of the plan, and other factors. This methodology will be submitted to Congress within 18 months of the enactment of this Act.

**Section 10330. Modernizing Computer and Data Systems of the Centers for Medicare & Medicaid Services to Support Improvements in Care Delivery**

The Secretary will develop a plan to modernize the computer and data systems of CMS within 9 months of the enactment of this Act.

**Section 10331. Public Reporting of Performance Information**

By January 1, 2011, the Secretary will develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program and other eligible professional participating in the Physician Quality Reporting Initiative. By January 1, 2013, the Secretary will also implement a plan for making information on physician performance publicly available through the website, which will include:

- Measures collected under the Physician Quality Reporting Initiative;
- An assessment of patient outcomes,;
- An assessment of continuity of care;
- An assessment of efficiency;
- An assessment of patient experience and family engagement; and
- An assessment of safety, effectiveness, and timeliness of care;

Care will be taken to make sure data is accurate, providers can review results, and data is timely. Patient information will not be disclosed on this website. By January 1, 2015, the Secretary will deliver a report to Congress on the website.

The Secretary may establish a demonstration program before January 1, 2019, to provide financial incentives to Medicare beneficiaries who receive services from high quality physicians based on the website data. Beneficiaries will not be required to pay increased premiums or have benefits reduced, and the Secretary will ensure that those without reasonable access to such care are not disadvantaged.

**Section 10332. Availability of Medicare Data for Performance Measurement**

*The following paragraph amends section 1874 of the Social Security Act.*

The standardized extracts of Medicare claims data for one or more geographic regions will be made available to qualified entities for the evaluation of the performance of providers of services and supplies, for a fee equal to the cost of providing the data. Any report using this data will: include a description of measures; be made available to providers to appeal and correct errors; only include data in an aggregate form; and be made available to the public. This section is effective January 1, 2012.

**Section 10333. Community-Based Collaborative Care Network Program**

*This section amends Part D of Title III of the Public Health Service Act.*

The Secretary may award grants to eligible entities to support community-based collaborative care networks, which are a consortium of health care providers that provide comprehensive coordinated and integrated services for low-income populations. A network will include a disproportionate share hospital and an FQHC. Priority will be given to networks that have the capability to provide the broadest range of services, have the broadest range of providers, and are a county or municipal department of health. Grant funds may be used to:

- Assist low-income individuals to access health services, enroll in health coverage, and obtain a regular primary care provider;
- Provide case management and care management;
- Perform health outreach using neighborhood health workers;
- Provide transportation;
- Expand capacity, including telehealth, after-hours service, and urgent care; and
- Provide direct patient care services.

The Secretary may limit grant funds spent on direct services provided by grantees of HRSA programs. There are authorized such sums as may be necessary for fiscal years 2011 through 2015 to carry out this section.

**Section 10334. Minority Health**

*The following paragraph amends section 1707 of the Public Health Service Act.*

The Office of Minority Health will be transferred to the Office of the Secretary. The Deputy Assistant Secretary for Minority Health will report directly to the Secretary and is authorized to award grants and contracts and enter into agreements to assure improved health status of racial and ethnic minorities, and will develop measures to evaluate the effectiveness of activities aimed at reducing health disparities. There are authorized such sums as may be necessary for fiscal years 2011 through 2016. The Secretary will biennially report on the activities of the Office of Minority Health.

*The following paragraph amends Title XVII of the Public Health Service Act.*

Each of the following agencies will establish an Office of Minority Health: Centers for Disease Control and Prevention, HRSA, Substance Abuse and Mental Health Services Administration, AHRQ, FDA, and CMS. The Secretary must designate an amount of funds from those appropriated for each agency to be used for this new office.

This section makes technical amendments to Title IV of the Public Health Service Act and adds the following: The Director of the National Institute on Minority Health and Health Disparities will plan, coordinate, review, and evaluate research and other activities on minority health and health disparities conducted by or supported by agencies within NIH.

**Section 10336. GAO Study and Report on Medicare Beneficiary Access to High-Quality Dialysis Services**

The Comptroller General will conduct a study on Medicare beneficiary access to high-quality dialysis services which include specified oral drugs for treatment of renal disease. A report on the study will be delivered to Congress within 1 year of the enactment of this Act.

## Subtitle D - Provisions Relating to Title IV

**Section 10402. Amendments to Subtitle B**

*The following paragraph amends section 4103 of this Act.*

In a 12-month period, a Medicare beneficiary may receive either an initial preventive physical examination or personalized prevention plan services.

**Section 10403. Amendments to Subtitle C**

*The following paragraph amends section 4201 of this Act.*

At least 20 percent of the competitive grants for disseminating evidence-based community preventive health activities will be awarded to rural and frontier areas.

**Section 10405. Amendments to Subtitle E**

*Subtitle E of title IV of this Act is amended by striking section 4401*. [Removes Sense of the Senate on CBO scoring]

**Section 10406. Amendment Relating to Waiving Coinsurance for Preventive Services**

*The following paragraph amends section 4103 of this Act.*

Medicare will pay 100 percent of the reasonable charge for medical nutrition therapy services recommended with a grade of A or B by the U.S. Preventive Services Task that are appropriate for the beneficiary. Medicare will also pay 100 percent of the actual charge for additional preventive services including clinical diagnostic laboratory.

**Section 10407. Better Diabetes Care**

This section may be cited as the "Catalyst to Better Diabetes Care Act of 2009." The Secretary will prepare a national diabetes report card on a biennial basis for each State, which will include aggregate health outcomes regarding preventive care practices, risk factors, and outcomes. Subsequent Report Cards will include trend analysis for the Nation and for each State.

The CDC will promote the education and training of physicians on the importance of birth and death certificate data and work with States to update their vital statistics systems. The Secretary will promote improvements to the collection of diabetes mortality data.

The Secretary will conduct a study of the impact of diabetes on the practice of medicine and the appropriateness of the level of diabetes medical education that should be required prior to licensure and board certification or recertification. There are authorized such sums as may be necessary to carry out this section.

**Section 10408. Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs**

The Secretary will award grants to small businesses to provide their employees with access to comprehensive workplace wellness programs. A comprehensive workplace wellness program must be open to all employees and include: health awareness initiatives; efforts to maximize employee engagement; initiatives to change unhealthy behaviors and lifestyle choices; and supportive environment efforts. There is authorized $200 million between fiscal years 2011 and 2015 to carry out this section.

**Section 10409. Cures Acceleration Network**

This Section may be cited as the "Cures Acceleration Network Act of 2009" and amends the Public Health Services Act.

High need cure- a drug or device that is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition and that the commercial market is unlikely to develop adequately or in a timely manner.

The Cures Acceleration Network (CAN) is established within the Office of the Director of the National Institutes of Health (NIH). This Office will award grants and contracts to eligible entities to accelerate the development of high need cures, including the development of medical products and behavioral therapies. CAN will:

- Conduct and support revolutionary advances in basic research;
- Award grants and contracts to advance the development of high need cures;
- Provide resources needed to develop high need cures;
- Reduce barriers between laboratory discoveries and clinical trials for new therapies; and
- Facilitate review in the FDA for cures funded by the CAN.

A Cures Acceleration Network Review Board, comprised of 24 members with 4 year terms, will be established to advise the Director of NIH on the activities on the CAN.

The Director of NIH will award grants and contracts to eligible entities to:

- Promote innovation in technologies supporting the advanced research, development and production of high need cures;
- Accelerate the development of high need cures; or
- Help the award recipient establish protocols that comply with FDA standards and meet regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product.

Eligible entities include: private or public research institutions, institutions of higher education, medical centers, biotechnology companies, disease and patient advocacy organizations, and academic research institutions.

Each Cures Acceleration Partnership Award and Cures Acceleration Grant Award will not exceed $15 million per project for the first fiscal year the project is funded. An eligible entity may apply for additional funding, not to exceed $15 million a year. An eligible entity receiving a Cures Acceleration Partnership Award must match $1 in non-Federal funds for every $3 awarded. The Director of NIH has flexible research authority to use other transactions to fund projects if it is determined the goals and objectives of this section cannot adequately be carried out through grants or contracts. Such awards will not exceed 20 percent of the funds available for such fiscal year.

The Director of NIH may suspend an award for noncompliance by an entity and may contract for periodic audits of funded projects. All grants or contracts under this section will be awarded on a competitive basis. There are authorized $500 million for fiscal year 2010 and such sums as may be necessary for subsequent years. Funds appropriated under this section will be available until expended.

**Section 10410. Centers of Excellence for Depression**

This section may be cited as the "Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009" or the "ENHANCED Act of 2009" and amends the Public Health Service Act.

The Secretary will award competitive 5-year grants to establish National Centers of Excellence for Depression. Each Center will collaborate to improve treatment standards, clinical guidelines, diagnostic protocols, and care coordination practice. Within one year of enactment of this Act, there will be no more than 20 Centers established, and by 2016 no more than 30.

Eligible entities must be an institution of higher education or public or private nonprofit research institution and submit an application with evidence that the entity:

- Provides comprehensive health services with a focus on mental health services or can coordinate with other entities to provide such services;
- Collaborates with other mental health providers as needed to address co-occurring mental illnesses; and
- Is capable of training health professionals about mental health.

Priority will be given to entities that have a demonstrated capacity to serve a targeted population, existing infrastructure to provide services, a location in an underserved population, proposed innovative approaches, use up-to-date science, and demonstrate capacity to have cooperative agreements with community mental health centers and other community entities to provide mental health, social and human services.

One recipient of a grant will be a coordinating center of excellence for depression. The coordinating center will:

- Develop, administer, and coordinate the network of Centers;
- Oversee and coordinate a national database to improve prevention programs, evidence-based interventions, and disease management for depressive disorders using data collected from the Centers;
- Lead a strategy to disseminate findings and activities of Centers through the database; and

- Serve as a liaison with the Substance Abuse and Mental Health Services Administration and any interagency forum on mental health.

Each Center will collaborate with other Centers in the network to: improve treatment standards, foster communication with other providers, leverage available community resources, and use electronic health records and telehealth technology. Each center will also carry out the following activities:

- Integrate research and practice in the development, implementation and dissemination of interventions;
- Involve a broad range of stakeholders;
- Provide training and technical assistance to mental health professionals; and
- Educate policy makers and the public about depressive disorders.

The Secretary will issue a report card to rate the performance of each Center, within 3 years after such Center is established and annually thereafter. The Secretary will report to Congress on the performance of the network as a whole. By September 20, 2015, the Secretary will make recommendations to the Centers on improvements and recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

An entity must agree to match $1 in non-Federal funds for every $5 of Federal grant dollars. There is authorized $100 million for each fiscal year 2011 through 2015, and $150 million for each year 2016 through 2020. For a fiscal year, each Center can receive no more than $5 million, and the coordinating center may receive no more than $10 million.

**Section 10411. Programs relating to Congenital Heart Disease**

This section may be cited as the "Congenital Heart Futures Act," and amends the Public Health Services Act.

A National Congenital Heart Disease Surveillance System will be established to facilitate further research on treatment use and to identify areas for educational outreach and prevention. The surveillance system will track the epidemiology of congenital heart disease and be managed by the CDC or the CDC will award a grant for a single entity to carry out these activities. The surveillance system will be available to the public, and the Secretary will ensure patient privacy is maintained.

The Director of the National Heart, Lung, and Blood Institute may expand, intensify, and coordinate research and related activities of the Institute on congenital heart disease. The Director may coordinate research efforts among multiple research intuitions, the Director will consider the application of research and other activities to minority and medically underserved communities. There are authorized such sums as may be necessary to carry out this section.

**Section 10412. Automated Defibrillation in Adam's Memory Act**

Funding is authorized for grants to develop and implement public access defibrillation programs through fiscal year 2014.

**Section 10413. Young Women's Breast Health Awareness and Support of Young Women Diagnosed with Breast Cancer**

This section may be cited as the "Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009" or the "EARLY Act" and amends the Public Health Service Act.

The CDC will conduct a national evidence-based education campaign to increase awareness of young women's knowledge regarding:

- Breast health in young women;
- Good breast health habits;
- The occurrence of breast cancer and risk factors;
- Evidence-based information to increase early detection; and
- The availability of information and resources for young women diagnosed with breast cancer.

The Secretary will award grants to establish national multimedia campaigns oriented to young women. The CDC will establish an advisory committee to assist in the education and multimedia campaigns.

The CDC will also conduct an education campaign among physicians and health care professionals to increase awareness:

- Of breast health, symptoms, early diagnosis and treatment of breast cancer in young women;
- On how to provide counseling to young women about breast health;
- Concerning the importance of discussing healthy behaviors and increasing awareness of wellness programs; and
- On when to provide referrals.

The CDC will conduct prevention research on breast cancer in young women. The Director of NIH will conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women. The Secretary will award grants to organizations and institutions to provide information and substantive assistance to young women diagnosed with breast cancer and pre-neoplastic breast diseases. There are allocated $9 million for each of fiscal years 2010 through 2014.

## Subtitle E - Provisions Relating to Title V

### Section 10501. Amendments to the Public Health Service Act, the Social Security Act, and Title V of this Act

*The following section will be added to Subtitle B of Title V of this Act.*

*Section 5104. Interagency Task Force to Assess and Improve Access to Health Care in the State of Alaska*

The Interagency Access to Health Care in Alaska Task Force is established to assess access to health care in Alaska and develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in Alaska. The Task Force will be appointed within 45 days after the enactment of this Act, and within 180 days the Task Force will submit a report to Congress with findings and recommendations.

*The following section will be added to Subtitle D of Title V of this Act.*

*Section 5315. Demonstration Grants for Family Nurse Practitioner Training Programs*

The Secretary will establish a training demonstration program for family nurse practitioners with 3-year grants to eligible entities to employ and provide 1-year training for nurse practitioner program graduates for careers as primary care providers in Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics (NMHCs).

An eligible entity is an FQHC or NMHC that submits an application. Priority will be given to FQHCs or NMHCs that: have sufficient infrastructure and capacity, will provide specialty rotations, provide sessions on high-volume and high-risk problems, and collaborate with other safety net providers. Eligible nurse practitioners will be licensed or eligible for licensure and demonstrate commitment to a career as a primary care provider in a FQHC or NMHC.

Each grant will not exceed $600,000 per year. The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency program to provide assistance to other grant recipients. There are authorized such sums as may be necessary to carry out this section for fiscal years 2011 through 2014.

*The following paragraph amends Part P of Title III of the Public Health Service Act.*

The Director of the CDC will establish a national diabetes prevention program aimed at adults at high risk for diabetes. This program will include:

- A grant program for community-based diabetes prevention program model sites;
- A program within the CDC to determine eligibility of entities to deliver such services;
- A training and outreach program for lifestyle intervention instructors; and
- Evaluation, monitoring, technical assistance, and applied research carried out by the CDC.

There are authorized such sums as may be necessary to carry out this section for fiscal years 2011 through 2014.

*Sections 5501(c) and 5502 of this Act are repealed.* [Removes Budget neutrality adjustment for Medicare bonus payments and Medicare FQHC improvements]

*The following 2 paragraphs amend Section 1834 of the Social Security Act.*

The Secretary will develop and implement a prospective payment system for payment for FQHC services to Medicare beneficiaries. This system will include a process for appropriately describing FQHC services and will establish payment rates based on these descriptions. FQHCs will be required to submit information to the Secretary to develop and implement this system by January 1, 2011.

The payment system will be implemented for cost reporting periods beginning after October 1, 2014. Initial payments will equal 100 percent of the estimated amount of reasonable costs for such services if the system had not been implemented. In subsequent years the payment rates will be increased by the percentage increase in the MEI or by the percentage increase in a market basket of FQHC goods and services.

*The following paragraph amends section 1833 of the Social Security Act.*

Regarding FQHC services for which payment is made under section 1834(o), the Medicare payment amounts will be 80 percent of the actual charge or the amount determined under such section. Payment amounts for an individual in a MA plan for FQHC services after implementation of the prospective payment plan will be what would have otherwise been provided (calculated as if "100 percent" were substituted for "80 percent").

*The following section will be added to Subtitle G of Title V of this Act.*

*Section 5606. State Grants to Health Care Providers Who Provide Services to a High Percentage of Medically Underserved Populations or Other Special Populations*

A State may award grants to providers who treat a high percentage of medically underserved populations or other special populations in such State. A grant program under this section may not be established in the same State entity that administers the Medicaid program. No Medicaid, Medicare of TRICARE program funds may be used to award grants or administer this grant program.

*The following 3 paragraphs amend Part C of Title VII of the Public Health Service Act.*

HRSA will establish a grant program for assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience. An eligible entity will be an accredited school of allopathic or osteopathic medicine. Priority will be given to entities that:

- Demonstrate a record of successfully training students who practice in underserved rural communities;
- Produce a high percentage of graduates who practice in these underserved areas;
- Demonstrate rural community institutional partnerships; and
- Have a plan for the long-term tracking of where graduates of such entity practice medicine.

Grant funds will be used to establish, improve, or expand a rural-focused training program. Such programs will have at least 10 students enrolled per year; require didactic coursework and clinical experience applicable to medical practice in underserved rural communities; and assist students with accessing residency training programs that train physicians to practice in underserved rural communities.

Within 60 days of enactment of this section, the Secretary will define "underserved rural community." Grant funds will supplement and not supplant any Federal, State, and local funds. There are authorized $4 million for each of fiscal years 2010 through 2013.

*The following paragraph amends section 768 of the Public Health Service Act.*

HRSA will award grants or contracts to eligible entities to provide training to graduate medical residents in preventive medicine specialties. Eligible entities will include accredited schools of public health, medicine, or osteopathic medicine; accredited nonprofit hospital; State, local or tribal health departments; and consortiums of 2 or more of these entities. Grant funds will be used to:

- Plan, develop, operate or participate in an accredited residency or internship program in preventive medicine or public health;
- Defray the cost of practicum experiences; and
- Establish, maintain or improve academic administrative units in preventive medicine and public health or programs that improve clinical teaching in preventive medicine and public health.

*The following paragraph amends section 770 of the Public Health Service Act.*

There are authorized $43 million for fiscal year 2011 and such sums as may be necessary each of fiscal years 2012 through 2015 to carry out Subpart 2- Public Health Workforce.

*The following 2 paragraphs amend section 331 of the Public Health Service Act.*

The Secretary may issue waivers to individuals (National Health Service Corps members) who have entered into contracts under the Scholarship Program or Loan Repayment Program under which the individuals are allowed to satisfy the obligated service requirement by providing half-time clinical practice. Some of the conditions for receiving a waiver include:

- The entity has requested a half-time health professional;
- The entity and Corps member agree in writing that the Corps member will perform half-time clinical practice; and
- The Corps member agrees in writing to fulfill all of the service obligations through half-time clinical practice that is double in length or for 2 years with a reduced award amount.

Full-time means a minimum of 40 hours a week in a clinical practice, for a minimum of 45 weeks per year. Half-time means a minimum of 20 hours per week (not to exceed 39 hours) in a clinical practice, for a minimum of 45 weeks per year.

*The following paragraph amends section 338B of the Public Health Service Act.*

For each year of obligated service under the Loan Repayment Program, the Secretary may pay up to $50,000 (increased from $35,000), and beginning in 2012 an additional amount to reflect inflation.

*The following paragraph amends section 5508 of this Act.*

Up to 20 percent of time spent teaching by a National Health Service Corps member may count toward full-time clinical practice of obligated service. Notwithstanding this, a Corps member participating in the teaching health centers graduate medical education program may count up 50 percent of time spent teaching toward obligated services.

**Section 10502. Infrastructure to Expand Access to Care**

There are appropriated $100 million for fiscal year 2010 to HHS for debt service, direct construction, or renovation of a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Such a facility will be affiliated with an academic health center at a public research university that contains a State's sole public academic medical and dental school. The State Governor must certify that:

- The new facility is critical for greater access to health care in the State;
- The facility is essential for the continued financial viability of the State's sole public medical and dental school;
- The request for Federal support is not more than 40 percent of the total cost of the new facility; and
- The State has established a dedicated funding mechanism to complete construction or renovation of the facility.

**Section 10503. Community Health Centers and the National Health Service Corps Fund**

A Community Health Center (CHC) Fund is established to expand and sustain national investment in community health centers and the National Health Service Corps. The CHC Fund will be administered through the Office of the Secretary of the Department of Health and Human Service.

Within the CHC Fund for fiscal years 2011 through 2015, *$9.5* billion is appropriated to provide enhanced funding for community health centers and $1.5 billion is allocated for the National Health Service Corps. An additional $1.5 billion is appropriated for the construction and renovation of community health centers. These funds will remain available until expended.

*(This section is modified in section 2303 of the Reconciliation Act)*

**Section 10504. Demonstration Project to Provide Access to Affordable Care**

Within 6 months of the date of enactment of this Act, HRSA will establish a 3-year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary will evaluate the feasibility of expanding the project to additional States. An eligible entity will be a State-based, nonprofit, public-private partnership. Each participating State will receive no more than $2 million to establish and carry out the project. There are authorized such sums as may be necessary to carry out this section.

## Subtitle F - Provisions Relating to Title VI

**Section 10602. Clarifications to Patient-Centered Outcomes Research**

The Patient-Centered Outcomes Research Institute will not allow the use of data from original research in work-for-hire contracts with individuals or entities that have a financial interest in the results, unless approved by a data use agreement with the Institute.

**Section 10603. Striking Provisions Relating to Individual Provider Application Fees**

This section contains technical corrections and modifies section 6401 of this Act.

The provider screening application fee for individual providers or suppliers is stricken. An application fee will be imposed on institutional providers and suppliers.

**Section 10605. Certain Other Providers Permitted to Conduct Face to Face Encounter for Home Health Services**

*The following paragraph amends section 6407 of this Act.*

In addition to a physician, a nurse practitioner or clinical nurse specialist working in collaboration with the physician, a certified nurse-midwife, or a physician assistant may conduct face-to-face encounters for certification of the need for home health services.

**Section 10606. Health Care Fraud Enforcement**

The United States Sentencing Commission will:

- Review the Federal Sentencing Guidelines for p convicted of Federal health care offenses;
- Amend the Sentencing Guidelines to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program will be evidence of the amount of intended loss by the defendant; and

- Amend the Sentencing Guidelines to provide a 2-level increase in the offense level for cases involving a loss of $1 to $7 million, a 3-level increase for cases involving a loss of $7 to $20 million, and a 4-level increase for cases involving a loss of over $20 million.

The U.S. Sentencing Commission will ensure that Federal Sentencing Guidelines reflect the serious harms associated with health care fraud, provide increased penalties for person convicted of health fraud, account for any aggravating or mitigating circumstances, and ensure that Sentencing Guidelines adequately meet the purposes of sentencing.

*The following paragraph amends section 1347 of Title 18 of United States Code.*

An individual need not have actual knowledge of this section or specific intent to commit health care fraud.

*The following paragraph amends the Civil Rights Institutionalized Persons Act.*

The Attorney General may subpoena access to any document, record, material, file, recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions that deprive persons residing in or confined to the institution of any rights, privileges, or immunities. Subpoenaed information may not used for any purpose other than to protect the abovementioned rights.

**Section 10607. State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation**

*This section amends Part P of Title III of the Public Health Service Act.*

The Secretary may award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation. Grants may be awarded for no more than a 5-year period, and the Secretary will ensure the diversity of alternatives funded. Each State will develop an alternative to current tort litigation that allows for the resolution of disputes over injuries allegedly caused by health care providers or organizations and promotes a reduction of health care errors by encouraging patient safety data collection and analysis. Each State will demonstrate how the alternative:

- Makes the medical liability system more reliable by increasing prompt and fair resolution of disputes;
- Encourages the efficient resolution of disputes and the disclosure of health care errors;
- Enhances patient safety by detecting, analyzing, and helping to reduce medical errors;
- Improves access to liability insurance;
- Fully informs patients about the differences in the alternative and current tort litigation;
- Provides patients the ability to opt out of or withdraw from the alternative at any time and pursue other options;
- Would not conflict with State law; and
- Would not limit or curtail a patient's existing legal rights or ability to file a claim.

Each state will identify sources and methods for compensation of claims resolved under the proposed alternative and establish a scope of jurisdiction for the alternative sufficient to evaluate its impact. A state will notify patients they are in this jurisdiction and tell them how they can opt out of the alternative.

States must submit an application to be reviewed by the Secretary in consultation with a review panel composed of relevant experts appointed by the Comptroller General. The review panel will include: patient advocates, health care providers, medical malpractice insurers, and patient safety experts.

The Secretary will provide technical assistance to States applying for or awarded these grants. Each State receiving a grant will submit annual reports to the Secretary evaluating the effectiveness of activities. The Secretary will submit a report to Congress on the analysis of these reports.

The Secretary will contract with a research organization to conduct an evaluation of the effectiveness of grants. The evaluation will begin within 18 months of implementation of the first funded program and will include:

- An analysis of grant effects on: the nature and number of disputes and claims where tort litigation was pursued, the dispositions of disputes and claims, the medical liability environment, health care quality, patient safety, patient and health care provider satisfaction with the alternative, and impact on utilization of medical services;
- An analysis for each state on the extent the alternative meets goals;
- A comparison among States on effectiveness of alternatives;
- A comparison of States receiving grants, States with a cap on non-economic damages, and States requiring an opinion on the merit of the claim.

The Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission will conduct independent reviews of alternative tort litigation to determine the impact on Medicare, Medicaid and CHIP.

There are appropriated $50 million for fiscal years 2011 through 2015 to carry out this section. The Secretary will hold 5 percent of the allocation to carry out the evaluation. The Secretary may also use up to $500,000 per State for planning grants from the allocation. Nothing in this Act limits any State efforts to establish alternatives to tort litigation.

**Section 10608. Extension of Medical Malpractice Coverage to Free Clinics**

This section amends section 224 of the Public Health Service Act to expand medical malpractice coverage to an officer, board member, employee or contractor of a free clinic.

**Section 10609. Labeling Changes**

*This section amends section 505 of the Federal Food, Drug, and Cosmetic Act.*

Regarding abbreviated new drug applications, if the proposed drug labeling differs from the listed drug due to a labeling revision the drug may be eligible for approval and will not be considered misbranded if certain criteria are met, including: the labeling revision does not include a change to the "Warnings" section and the sponsor agrees to submit revised labeling within 60 days of notification of an changes required by the Secretary.

## Subtitle H – Provisions Relating to Title IX

**Section 10901. Modifications to Excise Tax on High Cost Employer-Sponsored Health Coverage**

This section amends section 9001 of this Act to include longshore workers among high-risk professions.

**Section 10902. Inflation Adjustment of Limitation on Health Flexible Spending Arrangements under Cafeteria Plans**

*The following paragraph amends section 9005 of this Act.*

After December 31, *2013*, the dollar amount allowed for contributions to a health flexible spending arrangement will be increased by a cost-of-living adjustment (rounded to the lowest multiple of $50).

*(This section is modified in section 1403 of the Reconciliation Act)*

**Section 10903. Modification of Limitation on Charges by Charitable Hospitals**

*The following paragraph amends section 9007 of this Act.*

The amounts a nonprofit hospital can charge for emergency or other medically necessary care provided to individuals eligible under the financial assistance policy will be no more than the amounts generally billed to individuals with insurance covering such care.

**Section 10904. Modification of Annual Fee on Medical Device Manufacturers and Importers**

*(This section is repealed in section 1405 of the Reconciliation Act)*

**Section 10905. Modification of Annual Fee on Health Insurance Providers**

*The following 3 paragraphs amend section 9010 of this Act.*

The annual fee amount for health insurance providers will be equal to an amount that has the same ratio to the applicable amount as the covered entity's net premiums to the aggregate net premiums of all covered entities. The percentage of net premiums that will be taken into account is dependent on the covered entity's net premiums written during the calendar year as follows:

- Premiums of no more than $25 million will have 0 percent taken into account;
- Premiums between $25 and $50 million will have 50 percent taken into account; and
- Premiums of more than $50 million will have 100 percent taken into account.

The applicable amount will be *$8 billion* in 2011 and increase to *$14.3 billion* in 2017.

In this section health insurance will not include insurance for long-term care, Medicare supplemental insurance, coverage only for accident or disability insurance, or benefits not subject to requirements if offered as independent, noncoordinated benefits.

*(This section is modified in section 1406 of the Reconciliation Act)*

**Section 10906. Modifications to Additional Hospital Insurance Tax on High-Income Taxpayers**

This section amends section 9015 of this Act to increase the hospital tax rate by 0.9 percentage points (instead of 0.5) on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly).

**Section 10907. Excise Tax on Indoor Tanning Services in Lieu of Elective Cosmetic Medical Procedures**

*Section 9017 of this Act is voided.* [Removes the excise tax on elective cosmetic medical procedures]

*The following paragraph amends Subtitle D of the Internal Revenue Code.*

There will be a tax of ten percent on the amount paid for any indoor tanning service. Phototherapy services performed by a licensed medical professional are exempted. This tax will be paid by the individual receiving the service to the provider at the time of service and will apply to services provided after July 1, 2010.

**Section 10908. Exclusion for Assistance Provided to Participants in State Student Loan Repayment Programs for Certain Health Professionals**

*The following paragraph amends section 108 of the Internal Revenue Code.*

Gross income for an individual will not include any amount received under any State loan repayment or loan forgiveness program that is intended to increase the availability of health care services in underserved or health professional shortage areas.

**Section 10909. Expansion of Adoption Credit and Adoption Assistance Programs**

*The following 2 paragraphs amend the Internal Revenue Code.*

The aggregate amount of qualified adoption expenses that may be taken into consideration for tax credit is capped at $13,170. The tax credit for the adoption of a child with special needs will be $13,170. In taxable years after December 31, 2010, these dollar amounts will be increased by a cost-of-living adjustment.

The aggregate of the amounts paid or expenses incurred by the employer through an adoption assistance program for employees that may be taken into consideration for exclusion from the employee's gross income is capped at $13, 170. For the adoption of a child with special needs the exclusion will be $13,170. In taxable years after December 31, 2010, these dollar amounts will be increased by a cost-of-living adjustment.

All provisions and amendments of the Economic Growth and Tax Relief Reconciliation Act of 2001 are extended for an additional year, and will not apply to taxable, plan, or limitation years beginning after December 31, 2011.