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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Here we are again, Lord, a people in need of Your presence and power in order to meet life with courage and faith.

Today, strengthen the Members of this body with a faith that will ever choose the harder right over the easy expedient. Give them wisdom to follow Your example of sacrificial service, infusing them with the courage to do right as You give them the light to see it. Lord, lift from them the burden of loss and sorrow when forces beyond their control invade their lives and seek to rob them of Your peace. Bless them with the assurance that they are never alone, for You have promised never to forsake them. Fill their disappointments with Your strengthening presence, transforming their darkness into the glory of Your new dawn of hope and life.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK L. PRYOR led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 19, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK L. PRYOR, a Senator from the State of Arkansas, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. PRYOR thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will be in a period of morning business for an hour. Senators during that time will be permitted to speak for up to 10 minutes each. The majority will control the first 30 minutes and the Republicans will control the final 30 minutes.

Following morning business, the Senate will proceed to the consideration of S. 1963, which is the Caregivers and Veterans Omnibus Health Services Act. Debate on the bill will be limited to 30 minutes equally divided and controlled between Senators AKAKA and BURR or their designees. The only amendment in order to the bill is the Coburn amendment relating to the funding priorities in this bill. Debate on the Coburn amendment is limited to 3 hours, with Senator COBURN controlling 2 hours and Senator AKAKA controlling the final hour.

At 2 p.m., the Senate will resume debate on the nomination of David Hamilton to be U.S. circuit judge for the Seventh Circuit. Debate until 2:30 is going to be equally divided and controlled between Senators LEAHY and SESSIONS or their designees.

At 2:30 p.m., the Senate will proceed to a series of three rollcall votes. Those votes will be on confirmation of the Hamilton nomination, in relation to the Coburn amendment, and on passage of the veterans omnibus bill.

HEALTH CARE REFORM

Mr. REID. Mr. President, we have traveled a great distance to get where we stand today. With the bill we unveiled last night, we begin the last leg of this historic journey.

The American people and President Obama have asked us for health insurance reform. There are two things we must have above all: No. 1, make it more affordable for every American to live a healthy life, and No. 2, do so in a fiscally responsible way that helps our economy recover. Senate Democrats have listened, and we have written a bill that will save lives, save money, and save Medicare.

Since yesterday evening, the bill has been on the Internet for all to see. You will find it at democrats.senate.gov, but here is a quick summary of what is in that bill. And I say, Mr. President, this is a big bill. I was at a meeting with some other Senators this morning, and everyone acknowledged that no one can ever remember a bill that affects everybody in America as this bill does. It is a bill that has a lot of pages in it. But, as we know, it is printed the way all bills are printed. If we wanted to print it in smaller fashion—as books are written, for example—it

would be much smaller. It is a lot of words, and every word in it is important and necessary. Since yesterday evening, as I have indicated, this bill has been on the Internet. Everyone in the world can see this bill.

As the President asked us to do, this bill will not add a dime to the deficit—quite the opposite, in fact: It will cut it by $130 billion in the first 10 years and by as much as $¾ trillion in the first 20 years. We do this by keeping costs down. This critical reform will cost less than $85 billion a year over the next decade, well under President Obama's goal.

We will make sure every American can afford quality health care. We will make sure more than 30 million Americans who do not have health care today will soon have it. We will not only protect Medicare, but we will make it stronger.

These numbers are as impressive as they are important for our Nation's future, and though we are proud of these numbers, these figures, we cannot afford to overlook what this is really all about. More accurately, we cannot afford to overlook whom this is about.

This is about a parent who cannot take a child to the doctor because insurance is too expensive, their employer canceled it, or they lost their job. That is why we are making sure every American can afford good coverage.

This is about the small business in Nevada or someplace else in the country that had to lay off an employee because it couldn't afford skyrocketing health care premiums. That is why we are cutting those small business taxes.

It is about the woman with high cholesterol or the man with heart disease or the child with hay fever who can't get help and can't get insurance. That is why we are stopping insurance companies from deciding they would rather not give health care to the sick.

This is about the family who has to make a terrible choice between their mortgage and their medications. When this bill passes, the only choice they will have to make is which insurance company offers them the best coverage. They will have the choice to make, and it is a good choice. The choice is, which best suits their family?

This is also about mothers and sisters and wives and daughters who cannot get the proper testing they need to detect breast cancer. It is inexcusable that women cannot get the tests they need. That is why we are making prevention and wellness a priority.

For these families and these businesses, for our economy's renewal, our children's future, and our Nation's promise, the finish line is in sight. I am confident we will cross it soon. Once again, I am inviting my Republican colleagues to join us on the right side of history.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, for months we have been warning the American people of the Democrats' plans to raise premiums, raise taxes, and slash Medicare in order to fund more government. Americans know that is not reform, and unfortunately the majority has not been listening.

While two committees have publicly reported legislation, the bill we are being asked to consider was assembled behind closed doors, out of sight, and without input from the public for over the last 6 weeks. We are being told we must rush to pass this legislation, even though most of its provisions will not take effect for another 5 years, until 2014. That is a little bit like being asked to pay your mortgage 4 years before you are allowed to move into your house. Americans reasonably want to know: How much will it cost? Will their premiums go up? What is hidden in the fine print? Are favored interests or States getting sweetheart deals? The American people want to take the time to get this right.

Over here, we have the House bill and the Senate bill together, each of them roughly 2,000 pages. You see this massive bill to rewrite one-sixth of our economy, with stunning unintended consequences for ourselves and for our children and for our grandchildren.

The majority leader's bill is 2,074 pages long. When fully implemented—and the way to look at the true cost of this bill is how much it will cost over a 10-year period when it is fully implemented. What has been skillfully done in order to make it look less expensive, in this proposal, is phasing in benefits and taxes at different times. But when this 2,074-page bill is fully implemented, it will cost $2.5 trillion.

According to CBO, Federal health care spending will actually go up, not down, as a result of this mammoth effort to rewrite one-sixth of our economy. It cuts Medicare by $465 billion—nearly $½ trillion in cuts to a program that is so important to our seniors. Hospitals, Medicare Advantage, nursing homes, home health, hospice—all of those will be slashed in this $465 billion cut to Medicare. It raises taxes $493 billion. So you have here massive cuts in Medicare and massive tax increases.

Who gets hit? Who gets hit with the tax increases? You do. If you have insurance, you get taxed. If you do not have insurance, you get taxed. If you need a lifesaving medical device, you get taxed. If you need prescription medicines, you get taxed. There is also a new Medicare payroll tax.

What is the bottom line here? After weeks of drafting a bill behind closed doors, the majority has produced a bill that increases premiums, raises taxes, and slashes Medicare by $½ trillion, to create a new government program. This is not what the American people want. I do not believe they think this is reform. This is not the direction to take.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will be a period of morning business for 1 hour, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half.

The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent, during the time we control for the next half hour, that we be able to engage in a colloquy with other Senators.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. UDALL of New Mexico. Mr. President, for months we have gathered in this Chamber to talk about why we need a public option as part of health care reform. Almost every week the insurance companies provide another example of why a public option is critical to ensuring all Americans have access to quality, affordable health insurance. Our most recent examples come courtesy of two of America's largest insurance companies—Humana and CIGNA. Wall Street just completed its third quarter earnings season, and Humana and CIGNA released their reports a couple weeks ago. Let's just say that both companies did very well last quarter. Humana profits in the third quarter were up 65 percent over the same time last year. CIGNA profits in the third quarter were up 92 percent.

Senator BROWN has focused on the insurance company issue and has seen what is happening to the American people. This is happening at a time when 47 million Americans are without access to affordable health care. I will ask him to speak a little bit about the insurance company issue and what is happening.

Before doing so, the Republican leader was here on the floor, and he was talking about the numbers that were given by CBO. These are number crunchers. They are by nonpartisan folks. These are people who work very hard late at night. They have been

working to get out their numbers on the bill that we will have on the floor in a short while. I can't believe we are now hearing they don't like the CBO numbers. Both sides live by CBO numbers. That is the important thing for people to understand.

I yield to Senator BROWN.

Mr. BROWN. Mr. President, we are also joined by Senator REED of Rhode Island and Senator MERKLEY. They helped write the bill in the HELP Committee.

We know Aetna's CEO last year made $24 million. Of the top 10 insurance companies, the average CEO is paid $11 million per year. We know their profits have gone up 400 percent over the last 7 years. It is not so much that CEOs are paid so much. It is not just their profits and their CEO and top executive salaries, it is the business model that gets them there. When you think about what has happened to insurance companies, you are a big insurance company, you hire a bunch of bureaucrats to keep people from buying insurance, to invoke preexisting condition so somebody can't get insurance or to put limits on coverage so people can't get insurance. Then they hire bureaucrats on the other end to deny claims. Thirty percent of claims that are filed when people get sick—they turn their claims in to their insurance company from hospitals, doctors, treatments, they turn them in to the insurance company—30 percent are denied, initially. They are appealed sometimes and then they get reimbursement customers, someone who files a claim. But the fact that they have to fight the insurance companies while they are sick anyway or while they are advocating for their parents or a sister or husband or wife, these huge profits and huge executive salaries are based in denying care on preexisting conditions, on squeezing profits from customers.

Think of all the small businesses in Rhode Island, Oregon, New Mexico, and Arkansas, all the businesses that say they can't afford insurance anymore. They may have had huge price spikes because 1 person in a company out of 30 employees gets sick.

I don't care all that much about profits and CEO salaries. I do think it is immoral. But what I care about is that those profits and salaries are based on hurting people who have insurance or keeping people from having insurance.

Mr. KAUFMAN. How can a business do this? There is a real reason why they can do it. It is because there is no competition. Other companies can't do that. They can't treat the people who are customers the way the insurance companies do. When you look at the list, you can see why they get away with it. There is no competition. In the top 39 States out of 50, over 53 percent of the market share is with 2 companies. There is no competition right now in health care. That is the big reason why we need the public option. The reason for the public option is it allows us to have competition in these States where there is no competition at the present time. You can have gigantic profits. You can have CEOs making millions of dollars. You can have all these things. You can treat your customers poorly. You can do all these things because you don't have to worry about somebody coming into the business and offering them a good or better deal. That is what the public option does.

Mr. UDALL of New Mexico. I yield to Senator REED. I want to get him involved in this discussion.

Mr. REED. I thank Senator UDALL. Senator KAUFMAN has made an excellent point. What we have seen over the last several years, actually more than a decade, is increasing costs shifted to small business. Just this year, a 15-percent increase in small business premiums is anticipated, much higher than inflation. That is because there is no real competition. Rhode Island is on that map, where two companies control 8 percent of the market. There are forces, which have been illuminated, that drive up this constant increase in cost. One is profits. That is what private companies are organized to achieve. If we were directors of those companies, we would be trying to do that. But those profits drive two things: One, shareholder return, profitability of stock, and also compensation for executives. Those two phenomena will not be in place in a public option. It will be a not-for-profit cooperative arrangement. So the response will not be to shareholders or to self-aggrandizement of executives; it will be to delivering service. That is going to be a check.

What I find ironic in this discussion is the bold proponents of free markets who believe the free market can solve it are afraid of competition. They are afraid of a public option because they say: We can't compete with the Government. Their definition of competition is any competition. They are probably worried about 80 percent shared between two companies. This is a managed environment. Year in and year out, the insurance companies do great and small business does worse and worse.

I thank the Senator for yielding.

Mr. KAUFMAN. One final point. You can tell there is no competition when every year your premiums go up. The only other business I know similar to that—and I don't mean to hurt anybody's feelings—is the cable company and my TV bill. I know every year, no matter whether the inflation rate or the cost of living is down, I will get a notice in December—don't we all—basically saying my health care premiums are going up and my cable costs are going up. The reason is because both these are essentially operating as monopolies.

Mr. UDALL of New Mexico. I don't think the American people realize we have exempted the insurance companies from the antitrust laws. Those are laws you can move in, when there is a lack of competition in the market, when there are too few players in the market, to try to inject additional competition in the market. With the public option, the first thing we are trying to accomplish is to inject competition into the market, to have insurance companies be competing. This public option is going to help drive that cost down in a dramatic way.

Senator MERKLEY, who has worked on this legislation in his committees, joins us today. I hope he can talk a little bit about this issue also.

Mr. MERKLEY. Mr. President, there was a time when our colleagues across the aisle were in favor of competition. Correct me if I am wrong, but in the past, we used to have a highly regulated, noncompetitive airline industry. Was it not our good friends across the aisle who said we need to create competition so consumers have real choice and this will drive the cost of airline tickets down? Am I mixed up on that or is that fairly accurate?

Mr. UDALL of New Mexico. That is an absolutely accurate rendition.

Mr. MERKLEY. We are in a very similar situation here, where we have a noncompetitive industry, costs going through the roof. There is a basic factor at work which is, if we introduce competition in health care, service will improve, costs will come down.

Choice is much more important in this area than just about any other. If you are not satisfied with the cost of your insurance or the service you are receiving, then you should have multiple places to go. That is the underlying point of creating a health care marketplace or exchange, as it is called, so citizens can say: Here are all the plans competing against each other. What are they going to offer? A year later, if you are not happy, you get to switch, which says to every single insurance company, if we don't do well, we are going to lose our customers. That is the marketplace. That is competition. That is what we need in America. It will be helped by having a public option.

Mr. UDALL of New Mexico. Absolutely. No doubt about that.

Mr. MERKLEY. I can tell you a couple stories from Oregon. There was an article in the Bend Bulletin in October about two families.

One individual, Dale Evans, went to his doctor because he was experiencing pain in his chest. His doctor recommended he have an MRI to find out what was going on. The request was made three times. The insurance company turned it down three times. Because he didn't have this test, there was no diagnosis made of the cancerous tumor he had. His tumor proceeded to damage the nerves in his spinal cord and left him unable to walk. Then it became too large to be operated on. Mr. Evans died the following year, in 2008. As a result of the choice made by the insurance company, a for-profit insurance company, the test was not conducted and the individual died.

Richard Paulus of Bend, OR, has a similar case being filed right now. He, fortunately, is still alive. He was denied repeated requests for back surgery. His doctor argued for a second opinion. The request was made, turned down again. One factor is, you want to have an insurance company that is making decisions related to healing, not related to profits. The second factor is, one of the best ways to drive that, if Mr. Evans and Mr. Paulus were not satisfied, if they had a choice, they would be much more likely to create accountability with the company they are with right now.

Mr. UDALL of New Mexico. I wish to ask the Senator about those circumstances because he knows more of the details, but when you have insurance companies, these for-profit insurance companies we have been talking about that are making incredible profits, when you have insurance companies denying these claims, which is what you alluded to, what people need to realize is, what they have done is they have created an entire administrative bureaucracy within the insurance industry. It has flowed over into our medical providers, where doctors now tell me what they have to do is have people calling the insurance company to push to reverse these denials. So they have created a whole system which tamps down the ability of people to get care. What we are talking about in the public option is, you create a nonprofit. They are not in the business of making a profit. They are going to be in the business of providing health care, of doing the very best they can to provide health care. Why it will make the market competitive is they will not have all this administrative runaround. They will not have this going on.

Is that the Senator's understanding? They will look at the situation you have right there that you have described and they are going to say: It is clear this gentleman needs an MRI because we need to find out what is going on. So they will do the MRI, and then they will move quickly to the care. To me, that is the difference between what the Senator described, where insurance companies are trying to find a way to not pay out, to meet their bottom line, and to raise profits; whereas, a public option would be doing the opposite, focusing on the health care, focusing on future needs, focusing on providing what people need in the health care arena.

Mr. MERKLEY. Your point is well taken. The overhead in the private health care industry is now 25 to 30 percent. That is a whole lot of folks sitting around desks operating with paper rather than nurses and nurse practitioners and doctors practicing the craft of medicine, the craft of healing. Whereas, if you look at Medicare, instead of 25 to 30 percent overhead, it is somewhere around 3 percent—much less and, therefore, a lot more dollars going into actually assisting folks in getting well. Again, competition is going to drive down that overhead.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, the thing the American people should know about the health care plan Senator REID was down here talking about earlier—that we have unveiled here in the Senate—is it has a public option in it. So the public option will be there to provide competition. It will be there to provide the very best care. And it will be there to make sure we keep these insurance companies honest. That is what we are trying to do here: to make sure there is competition in the market, to make sure the insurance companies are honest.

Mr. MERKLEY. Yes. The reason we have lost competition is twofold. One, in many markets, a single company dominates the market. Second, even if you have multiple companies, they are exempt from the antitrust laws and, therefore they can communicate with each other in a way that reduces or even eliminates real competition. That is why this is so important.

There is one feature of this public option that I think is important to recognize. It represents a huge compromise, and that compromise is that many of our Senators said: We are not sure our folks back home are quite sold on this idea, and we do not want to see it ''forced on them.'' Quite frankly, I think it would be good to have competition everywhere in the country, everyone have more choices. But in deference to that Federalist tradition in America, in deference to the laboratory of State experimentation, a provision has been included in Senator REID's merged bill that says if a State does not want to participate, it can opt out.

So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to be forced to have it, because no State will be put in that position. Any State can choose to say: We do not wish to participate. I think that means we will have a situation where many States—most States, I believe—perhaps virtually all States will say: We do want to participate. But those States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition and choice later on.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, I think that is a great example of how we all work here together to find a compromise that works for everyone. I realize there are Democratic Senators and Republican Senators—and the same for Governors—who may want to do things differently in their State. So what we have done here is give them the option of opting out in this public option we are providing.

I personally—looking at the facts, and looking at the situation—do not know why a State would want to opt out. But there is going to be the check and balance there of the legislature having to pass a law, the Governor having to sign it, and say: We do not want to have anything to do with the public option.

But we realize with a public option you bring competition to the market, you expose these high administrative costs you talked about. One of the things people do not realize, on administrative costs, is, the Federal Government runs the Medicare Program. Here you have a program that when I go to town hall meetings, I say: Raise your hand if you are on Medicare. They will put their hand up. And I will say: Keep your hand up if you like Medicare. So they will raise their hand, and they will keep it up.

Ninety-five percent of the people like Medicare. Well, Medicare has a 3-percent—3-percent—administrative cost. As the Senator said earlier, the insurance companies we are dealing with have anywhere from 25 to 30 percent administrative costs. So if you put a public option out there, you are going to make there be competition.

Senator MERKLEY.

Mr. MERKLEY. I say to the Senator, let me give you an example of how that competition can work in a health insurance marketplace. In Oregon, we have a public option in workers compensation, which is health insurance for injuries that occur on the job. We have had this public option for 80 years. It did not work that well. It was not that well designed, and it was not that well managed.

About 20 years ago, a group of businesses got together, and the businesses said: We need a better insurance policy. We need a better competitive market for on-the-job health insurance. So in a deal that was called the Mahonia Hall deal, Mahonia Hall rewrote and improved the management of our public option. The result is, rates today in workers compensation in Oregon are half of what they were 20 years ago, because competition was introduced, efficiencies occurred, service improved. I can tell you, there is not a business in Oregon to be found campaigning to eliminate the State accident insurance fund, which is a public option in work-based health care.

Our colleague SHELDON WHITEHOUSE was involved in establishing a very similar program in Rhode Island. Their workers comp, he told me—and I think he has told this Chamber—introduced by Rhode Island adopting a work-based health care public option resulted in their rates dropping by half.

Wouldn't it be great if competition could reduce health care costs in America rather than having 10 to 15 percent increases every single year?

Mr. UDALL of New Mexico. Yes. I say to the Senator, you hit it on the head. I have been here on the floor with Senator WHITEHOUSE—I know Senator REID was just here—participating in a colloquy.

The point that both of them, I think, make is when you inject a public option into the insurance market—

whether it is health insurance, whether it is workers compensation—you inject competition. And by injecting that competition, you make the marketplace work a lot better. That is what we are striving for here today.

Senator MERKLEY.

Mr. MERKLEY. There are folks who have said: Well, now, hold on. Isn't this a government takeover of health care? Since that has been said so many times on this floor by those who oppose health care reform, I think we should address it directly. Introducing a competitor does not have the government taking over health care. It is an option citizens can choose—if they are not satisfied with the current performance—competing on a level playing field. This is exactly what you need when you have markets that have lost their competition.

It is important to note this phrase ''government takeover'' came out of a study that was contracted for by my colleagues across the aisle to say: How can we defeat health care? They polled folks in America and said: What are the scariest terms we can use—even though we do not know what the plan is; even though we do not know whether the plan is going to invest in prevention; we do not know if the plan is going to invest in disease management; we do not know if the plan is going to have healthy choice incentives that will help improve the quality of life of Americans and decrease health care costs; we do not know if we will have insurance reforms that will get rid of dumping, the practice of throwing people off their health care plan once they get sick; we do not know whether there will be reforms that say there will be guaranteed issue, you cannot be denied the opportunity to have health care because of preexisting conditions. We do not know any of that, but whatever it is, we are going to be against it. So let's do a study now. And they contracted to do the studies. Let's find out how to scare Americans. The result was: Let's call it a government takeover.

I have to tell you, this is too important an issue to the citizens of our Nation. Health care touches every individual, touches every small business trying to succeed. It touches every large business trying to compete around the world, with much more efficient—much more efficient—health care systems in other countries. It is too important than to do studies to try to find words to scare Americans.

How about we try to solve problems in this Chamber? I am going to tell you, I think this bill put forward last night by Majority Leader REID is about solving a problem absolutely critical to our economy, critical to our small businesses, critical to the quality of life of our families.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, you are exactly right. Senator REID has put a merged proposal on the floor, and do you know what the response is we have seen? I like your comments on this. The response we have seen I find amazing, I find absolutely amazing, because here is what we are facing.

The American people want health care reform, so we have announced we are going to put a bill on the floor to reform health care. We have been working on it for months. It is out of two committees. We have brought it together. So what do we have to do in the Senate to move forward? We file a motion to proceed. OK. That is just to proceed. You are not even on the bill.

Do you know what is going to happen? The Republicans are going to step forward, their leadership is going to step forward, and they are going to say: No, no, we are not going to agree to that. We are not going to agree to even proceed to the bill.

So we are going to have to file cloture. When we file a cloture motion today, it is going to take 2 days before that cloture motion ripens. Then we are going to have a cloture vote. Then 30 more hours are going to expire. They are going to require us to use all that time. Even though we may be in a quorum call and not doing any debate, they are going to require that. Then, believe it or not, they are going to require us—these wonderful clerks who work up here—they are going to require them to stand up for 50 hours and read that bill on the floor—50 hours. The normal thing we do to get to something is we waive the reading. But they are going to require it.

What does the Senator think of that approach? I cannot understand that.

Mr. MERKLEY. Many Americans are familiar with the tradition of a filibuster, and they envision it where Senators stand up and speak and speak on an issue of principle. That was used very rarely in the past. In fact, now all that is required is for one Senator to object to unanimous consent, and then you need to have a 60-vote test.

This 60-vote test is most often used at the end of a debate to say: Do we go to a final vote? Are we going to wrap up debate and go to a final vote? But in this case, as the Senator has described it, it is going to be used even to hold a debate on health care in this Chamber.

All my life—I first came to this Chamber when I was an intern for Senator Hatfield in 1976—all my life, I have heard the Senate described as ''the world's greatest deliberative body.'' Well, that is a pretty cool thing. But are you telling me that folks are going to try to block this Chamber from even debating health care?

Mr. UDALL of New Mexico. That is exactly what I am saying. We have worked hard. The majority has worked hard. We put together a bill. We have had hearings—Democrats and Republicans—in those committees. When we file a motion to proceed, we are not even on the bill, we cannot amend the bill. When we file that motion to proceed, they are going to require we take 2 full days, and then another 30 hours, and then demand we read the bill on the Senate floor.

I see Senator ALEXANDER in the Chamber. I know there are good friends of ours on the other side who do not want to see that kind of thing proceed. But a couple of Senators can muck up the whole works here and slow this thing down.

I think the American people want us to move forward with health care. I think they want us to get something done that provides health care for people, that provides choices, that keeps people's doctors, that puts competition in the market—all of those kinds of things.

Senator MERKLEY.

Mr. MERKLEY. I join the Senator in saying to all my colleagues, do not fear debate on health care. We are here, and it is our job to come and debate. It is our job to come and talk about how important it is to have insurance reforms so people are not barred because of preexisting conditions, people are not dumped after a decade of being provided insurance because they get sick.

It is so important we have this debate, and I look forward to having it, and hope all colleagues will join in saying: Yes, no matter which side of this issue you are on, it is time to debate, as our citizens have sent us here to do.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, thank you. Thank you for joining me in this colloquy today.

I thank the Acting President pro tempore and yield back any time at this point.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I wonder if you could let me know when I have consumed 9 minutes.

The ACTING PRESIDENT pro tempore. The Senator will be so notified.

Mr. ALEXANDER. Thank you, Mr. President.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, I was listening to my friends on the Democratic side. I wish they could have been in the Senate 4 or 5 years ago. Actually that would have reduced our numbers, so as much as I like them, I would not have wished that. If they had been here, they might have been some help in arguing to the Democrats who blocked Miguel Estrada from even having an up-or-down vote, who blocked Judge Pryor of Alabama from having an up-or-down vote. The Democrats at that time seemed to argue a completely different point of view.

What we want on the Republican side is very simple.

You see this bill I am leaning against? This is the new bill. This is the Harry Reid—the distinguished majority leader's health bill. We want to make sure the American people have a chance to read it and they have a chance to know exactly what it costs and they have a chance to know exactly how it affects them. That is not

an unreasonable request, we don't think. That is the way the Senate works. That is our job.

When it came to the Defense authorization bill, we spent a couple of weeks doing that. When it came to No Child Left Behind, the Education bill, we spent 7 weeks going through it, and neither of those bills was 2,074 pages long. The Homeland Security bill took 7 weeks. The Energy bill in 2002 took 8 weeks. A farm bill last year took 4 weeks. So we have a little reading to do, a little work to do. We have done some preliminary reading, but what we want to make sure of is that the American people read the bill, know what it costs, and know how it affects them because health care is a very personal matter.

I have done some reading since the bill came out last night. I was also a little bit amused to hear our friends complaining about how we are slowing things down. Well, this bill has been hidden in the majority leader's office for 6 weeks. He wouldn't let any of us read it. I don't know who he has been in there with writing it, but I guess it takes a long time to write a 2,074-page bill. But he didn't bring it out until last night, and now we have it printed out. Now he wants to vote on Saturday.

Well, that is all right with us if he wants to vote on Saturday or Sunday or Monday or Thanksgiving Day. We are going to be here because these are the most important set of votes we are ever likely to take in this body, at least during the time I am here.

Let me give a preliminary report to the American people in terms of the Thanksgiving spirit about this bill. It came out with a lot of fanfare. It has been hidden in the majority leader's office for 6 weeks, but here is my early verdict in terms of the Thanksgiving season. This is the same turkey you saw in August, and it is not going to taste any better in November. It is not much different than what worried you in August. In fact, it has gotten a little bit worse.

If I may, let me give just a few thoughts about the bill. Why would I say it is the same turkey you saw in August, and you didn't like it in August? Well, it is still going to have higher premiums for you to pay. It is still going to have higher taxes for you to pay. There are still going to be big Medicare cuts for seniors to absorb in their program. And while it is a little too early to tell, there is very likely to be more Federal debt. It is still a big bill—more than 2,000 pages—and if you wait until it is fully implemented, it is still somewhere between $2 trillion and $3 trillion over a 10-year period of time.

The Republican Budget Committee staff has looked it over carefully since last night and says it is about $2.5 trillion in spending over 10 years. It still starts taxing you and cutting your benefits immediately if you are on Medicare, but the benefits that come to you for the most part don't start until 2014.

Let me be a little specific about it. It still leaves 24 million Americans uninsured, although it reduces the number of uninsured Americans by 31 million according to the Congressional Budget Office. It still doesn't take care of the physicians reimbursement. One of the most difficult issues we have is what we should do about the amount of money we allow doctors to make when they see patients who are in the government programs. In the Medicare Program, doctors only make about 83 percent of what they would be paid if they were seeing the 177 million of us who have private insurance. We regulate that. Doctors who see Medicaid patients, about 60 million patients in the low-income government program, only get paid about 63 percent, which is set by the state, of what they would get paid if they saw somebody who has a private policy. In fact, 50 percent of doctors will not see new patients in the biggest government program we have—Medicaid. So as you can imagine, a lot of doctors can't see the people in the government program.

This new bill takes care of the doctors reimbursement for only 1 year. It leaves out about $250 billion over the 10-year period of time, so add that in when you are figuring out whether this adds to the debt.

Does it have higher premiums? Yes, it does. The Congressional Budget Office says the new government plan in this bill would have premiums that are higher than private plans. Your common sense would also tell you that, because if we have $800 billion in new taxes somebody is going to have to pay those taxes. If they are on medical devices or insurance policies, do you think the insurance company is just going to pay those taxes? No, they are not. They are going to pass those on to you in the form of premiums. So higher taxes mean higher premiums.

There is also $28 billion in new taxes from employers who have to pay a fine when they don't provide employer-based insurance. Under this bill, the chances are very good—in fact, the Congressional Budget Office says maybe 5 million Americans will lose their insurance. How could they lose their insurance under a bill such as this? The reason would be that the employer will read this big, complicated thing and say: I don't want anything to do with that. I will pay the fine. I will write a check to the government. Then I will write a letter to all of my employees and say: Congratulations, there is a new government plan, and you are in it.

That is going to happen to millions of Americans who have private insurance today through their employers. The employer is going to simply say it is cheaper for them to pay the fine. It is easier for them to pay the fine than deal with this 2,074-page bill.

According to the Congressional Budget Office, 5 million Americans—and others think many millions more—will lose their employer-based insurance, and they will end up in the government plan. I just said in the government plan, the largest one we have, Medicaid for low-income Americans, 50 percent of doctors will not see those patients—new patients—because of the low reimbursement rates. The bill still relies on the States to pay for some of Medicaid. That is not new either. That concerns me greatly as a former Governor. Our current Democratic Governor said the bills he had seen so far would add over $1 billion to State taxes or spending over the next 5 years which, in my way of thinking, would require a new State income tax that would seriously damage higher education or both.

In other words, we are saying give us a pat on the back. Thank you very much for expanding Medicaid, and I am going to send some of the bill to the States and let the States either raise college tuition or raise taxes or cut spending or put in new taxes to pay for it.

There is also a new Medicare tax. The money that is raised from that, the Medicare payroll tax, is not spent on grandma, not spent on Medicare; it is spent on a new program. So we are going to cut Medicare and tax Medicare and not spend it on Medicare, which is going broke in 2015, according to its trustees. We have a new government program. Those are new. But, basically, it is still the same turkey you didn't like in August, and it is not going to taste any better at Thanksgiving dinner on Thursday.

We need to start over. We need to go in the right direction. We need to cut costs. Republicans have offered a number of ways to do that: small business health plans, reducing junk lawsuits against doctors, competition across State lines. All of these steps would cut costs. We don't need a 2,074-page bill. We need to take it step by step in the right direction to cut health care costs, and when we take those five or six steps, we can take five or six more.

I thank the President and yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Nebraska is recognized.

Mr. JOHANNS. Mr. President, I wish to compliment the Senator on his very excellent presentation on a bill we just got in the middle of the night last night. I am a little bit tempted to ask the Senator if I could have a copy of that bill on my desk, but the less we have to handle it, the less we risk bodily injury, so that is all right. Just keep it right there at your desk.

I wish to zero in on one issue today. It is a very important issue to Nebraskans. It is a very important issue to Americans. That is the issue of abortion. An overwhelming majority of Americans suggest—take the position, I should say—that we should not use Federal funds for abortions. Just yesterday, I was looking at an article and it said six in ten Americans favor a ban on using Federal funds for abortions. I have found over and over again that Nebraskans feel the same way.

A constituent in Gretna, NE, said to me, and I am quoting:

Please know that I do support some health care reform; however, I cannot in good conscience support any legislation that contains any abortion mandates.

Someone from Bellevue, NE, said, and I am quoting again:

I am writing to urge you to ensure that language is included in any health care reform proposal or bill to explicitly exclude abortion . . . The use of my tax dollars forces me to support a procedure that is against my conscience.

So as we move forward, we need to focus on what people are saying to us. That is why in this bill we need the exact language in the House bill.

The Stupak amendment is the essence of a continuation of current law. Don't be fooled by those who suggest this is something new and different. The Hyde law prohibits Federal funding of abortion through Federal programs such as Medicaid. It prohibits Federal funding for private health insurance policies that cover abortion. An example is the current Federal Employees Health Benefits Program. The 250 participating health plans do not cover elective abortions. Federal employees pay a share of the cost. The Federal Government pays the balance—or the taxpayers. Federal employees cannot opt for elective abortion coverage because taxpayer dollars are subsidizing the cost of the employee plans.

As many have said during this debate, if it is good enough for Federal employees, well, it should be good enough for the citizens.

The Stupak-Ellsworth-Pitts amendment says: New government subsidies could not be used to purchase an insurance plan that covers abortion. The proposed government insurance plan also could not cover abortion. However, the stark and alarming differences that exist in the Senate bill are immediately obvious.

The Senate bill says: People who receive a new government subsidy could—could—enroll in an insurance plan that covers abortion. It requires—requires—at least one plan on the insurance exchange to offer abortion services.

Supporters say: Don't worry. Public funds would be segregated, so they wouldn't be used for abortion. But this provides no solace whatsoever. It is impossible to segregate funds. How will the government ensure citizens who receive a subsidy to buy a health insurance plan do not use those Federal dollars to pay for health insurance premiums?

Put another way, citizens get charged a premium that includes abortion coverage. The taxpayers pay a percent of the premium. Who can determine what dollar went here or what dollar went there? Well, as many have pointed out already, it is a shell game—nothing more, nothing less.

The Senate bill makes a sharp detour from current law. The very clear line established by the Hyde amendment is obliterated. The Federal Employees Health Benefits Plan does not allow this shell game and neither should this new regime.

National Right to Life is not fooled by this game. They call this provision ''completely unacceptable.'' It was remarkable how quickly they read this language and saw through it. National Right to Life goes on to say that it ''closely mirrors the original House language that was rejected by 64 Democrats.'' I am going to quote:

It tries to conceal that unpopular reality with layers of contrived definitions and hollow bookkeeping requirements.

I stand here today to say to National Right to Life, thank you for standing up for life. I hope more will do the same. You are absolutely correct in saying that it would ''require coverage of any and all abortions throughout the public option program. This would be Federal Government funding of abortion, no matter how hard they try to disguise it.'' They weren't fooled.

My best view of this is that other pro-life leaders will courageously stand up today and tell Americans they should not be fooled either. We have to draw a line. This isn't a partisan issue.

Last week, a Democratic colleague said:

What is clear is that for this bill to be successful, there can be no taxpayer funding for abortion.

Yet the Stupak-Ellsworth-Pitts protections are stripped from this bill. Since it is not in the underlying bill, I want to be very candid, I don't see it in the final bill. I don't believe there are enough pro-life Senators to break a filibuster to make this a part of the final bill. That is why this motion to proceed we will be voting on in hours has become the key vote on abortion. It is the key pro-life vote.

Some say cloture on a motion to proceed is just a procedural effort. It begins debate, and then you can do amendments and potentially even vote the bill down. The facts suggest otherwise. Listen to this, from the Congressional Research Service: Between the 106th and 110th Congress, there were 41 cases in which the U.S. Senate approved a motion to proceed and eventually then voted on final passage; 40 of those 41 bills received final approval. In other words, all but one passed into law. Well, that tells us all we need to know. This motion to proceed on this life issue is critical.

Some of my colleagues would argue that if we don't like the bill, we must not block the opportunity to amend it; therefore, they would say we should vote for the motion to proceed. I don't think any pro-life Senator could take that position, and here is why: If we proceed to the bill, any changes will require 60 votes. I sincerely wish there were 60 pro-life votes in the Senate, but by my count I don't get there; therefore, we won't be able to change this. If there is a Senator willing to suggest otherwise, I respectfully invite him or her to come to the floor and share the list of 60 Senators who are willing to vote for a provision that ensures the Stupak amendment will be there. I don't think that is going to happen.

So it comes down to this: If you don't believe tax dollars should fund abortion, vote against the motion to proceed. It is our last chance to protect life in this debate.

Congressman STUPAK and about 40 of his Democratic colleagues stood strong on their pro-life convictions, and they literally changed the outcome in the House. They stared the Speaker in the eye and said, about this procedural vote: Look, if it is not pro-life, we are not there. And the Speaker had no choice but to put the Stupak amendment up for a vote. Over 40 courageous Congressmen stuck to their convictions, and they made a difference.

Today in the Senate, we don't need 40 Democrats to stand up for what is right; we need just 1. If just one pro-life Democrat would say: I will not vote to move this bill until it is fixed, until it is truly pro-life, that would happen.

Those who say they are pro-life but refuse to take that stand, I worry they are not standing up for life.

I have a record of voting pro-life. I know how I am going to vote on this, because it is the right thing to do. I ask for a pro-life Senator to come down here and stand up on this bill. Pro-life Americans are waiting, and they are not fooled.

I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, here you have it, what we have been waiting for for weeks and weeks, what has been put together behind closed doors. People all across the country have seen the doors behind which people, in secret, have been writing this bill. It is 2,074 pages. Some people call it remarkable; I call it a monstrosity.

The leader of the majority, Senator REID, has said that of all the bills we have seen, it will be the best. Mr. President, it is the best of the worst. It just looks like more of the same. All of the things I have been talking about—it still does those sorts of things. It still raises taxes on Americans, higher payroll taxes—and this is the Associated Press talking, not just me. Companies will pay a fee. That is from the Associated Press as well. It adds an array of tax increases, a rise in payroll taxes. That is from the Washington Post. It relies primarily on a new tax. That comes from the Washington Post as well. Then the New York Times says: New taxes and new fees. It is more of the same. It is the best of the worst.

What about Medicare cuts? Oh, they are in here, too, you better believe it. It is relying on cuts in future Medicare spending to cover costs. That is from the Associated Press. It is financed through billions of dollars in Medicare cuts. That is from the Washington Post. There will be reductions in Medicare. It is all in here—taking away the

health care of the seniors of this country, who have relied on Medicare and have been promised Medicare, to start a brandnew program which is in these 2,074 pages. It is just wrong.

Then look at the budget gimmicks. The costs of this legislation—and the CBO came up with some number, but it is not what the real cost is. This thing is going to cost $2.5 trillion over a 10-year period. They try to get the number down. How do they do it? They start collecting taxes on day one, but until they actually implement the program—the things that are supposed to help Americans, they have delayed those things through 2014. Here we are in 2009, and the people who are watching at home and saying: This is going to help me next week, forget it, wait another 5 years. That is the way they maneuver and manipulate the numbers.

Here we have it—a bill that still raises taxes, still cuts Medicare, uses lots of budget gimmicks, and will cost the American people trillions and trillions of dollars.

Mr. President, obviously health care is one of the most important issues Congress is going to take up this year and maybe in our careers in the Senate. This may be the most important issue and bill we are ever asked to vote upon.

I travel home to Wyoming every weekend. I talk to people. I was there for 5 days over Veterans Day.

I say to them: What do you need? What do you think? What are your thoughts on this?

They say: Deliver to Washington a clear and simple message: Fix what is wrong with the health care system. Whatever you do, don't make things worse for me.

I have town meetings and ask people: Do you think it is going to cost more or less if this is passed? And I have had telephone townhall meetings with folks around Wyoming, and there is a way you can poll and ask people their ideas. People believe it is going to cost them more. I ask: Is your care going to be better or worse? People believe it is going to be worse, that they are going to pay more and get less.

That is not the kind of value the people of Wyoming or anywhere in America want. It is not the kind of work they expect out of Congress. They want us to fix what is wrong with the health care system. As Senator ALEXANDER said earlier, we need a step-by-step approach in the right direction, dealing with the things we can do to improve the system. Whatever you do, they say, don't make matters worse for me. That is what people care about. That is what they care about in the telephone townhall meetings and the meetings we have in person.

They say: What does this mean for me and my family? What will it mean to our health care? What happens if I get sick? That is what people care about. None of them want to read this bill, and probably none of them will read the bill. It is on the Internet, after weeks behind closed doors. I hope the people in Wyoming and around America read it so that they know about the travesties in the bill and the impact it will have on them personally. It is the wrong prescription for America. And it is not just me saying that.

Yesterday, there was an article in the Wall Street Journal, and the dean of Harvard Medical School—it is in Boston, which is where they have this whole Massachusetts health care plan. He said that it is not working in Massachusetts and that this is not going to work for America. He gave the health care bill we are looking at in this Congress a failing grade. It doesn't do a good job in dealing with costs, access, or quality. It misses the boat on all of them.

The people who believe this is going to be helpful collectively are delusional, absolutely wrong. They have no idea how this will be for the health of our Nation. Yet this is what we are looking at. As Senator REID says, what we have seen, of all the bills he has seen, it is the best. It may be, but it is the best of the worst. It looks like more of the same.

Some people in Wyoming in townhall meetings say: Don't take away my freedom to choose the plan I want. Well, this bill sort of does that. If they have something they like, this has a lot of numbers and mandatory sets in there—the sorts of things that will take away freedoms of the people to choose specifically what they want because of all of the mandates this has to cover, and it has to cover this, that, and the next thing. A lot of people don't want that.

People also say: Don't cut my Medicare. I hear that all around Wyoming and around the country. There are 11 million people on Medicare Advantage. That Medicare Advantage Program is actually the only Medicare Program that does a good job of working on preventive care and coordinating care, and that is going to be slashed under this program. So we are going to take away prevention and the things that have to do with coordinated care. Just take a look at this monstrosity of over 2,000 pages.

People say: Don't cut my Medicare or raise my taxes. We are looking at 10.2 percent unemployment right now. This is not the time to raise taxes. It is just not the time. We need to focus on getting jobs moving in the economy and helping people hire new people. With that 10.2 percent unemployment, the last thing you want to do is raise taxes, but that is what this bill will do. That is not just me saying that; it is also the AP, the Washington Post, and the New York Times. All along the way, it is higher payroll taxes, companies paying fees, raising payroll taxes, primarily new taxes and fees—one after another—to pay for something the American people do not want.

The people say: Don't make me pay more for my family's health care. But that is what is going to happen across the board. Premiums are going to increase, the premiums for people who have insurance—the premiums people pay who have insurance. For the 85 percent of Americans who have insurance, those costs will go up. This plan was designed, theoretically, when it was announced a year ago, to get costs down, to get premium costs down. This raises the premiums for the American people.

We are living in a time and in an economy when people say they can't afford this sort of a bill. The American people don't want it.

I travel around the State and visit with people. I visited with a young lady from Cody, WY, who has health insurance through her job, and she likes it. She takes care of her family. She found out that because of increasing premiums—which will get worse if this bill passes—the raises people think they are going to get will not be coming to them. In some places, they have had their pay cut a little bit so they can continue with the health care they have. They like the care, but they don't like the cost of their care. Again, this doesn't get the costs down for American families. Premiums will go up.

This is what we have been seeing all across the country. Whether it is independent people, whether it is people who work for government, whether it is people who sell insurance or those who buy insurance or people who need insurance, across the board, people say these atrocious health care proposals will make matters worse for the families, for the men and women of this country. They are going to be paid for not just by them but also by the young people, as the debt continues to accumulate in our Nation and goes on to impact the young people of this Nation.

The people of Wyoming want practical, commonsense health care reform—the kinds of reforms that will drive down the cost of medical care, that will improve access to providers, that will create more choices. They don't want things that will increase the costs or things that will limit access or things that will take away their choices.

Obviously, the majority leader and the Democrats in Congress have a very different plan in mind. Their legislation is going to force upon Americans higher health insurance costs through higher premiums, higher taxes, Medicare cuts, and more government control over health care decisions. That is not reform.

There are only two physicians in the Senate. The two of us bring a unique perspective to the health care debate. I practice medicine, taking care of families from all across the great State of Wyoming. I have dedicated my life's work to helping patients live longer, live healthier, and stay well. I can say, without reservation, in this Nation, we do offer some of the finest medical care

in the world. I am not blind to the fact that our health care system has failings. I have seen them firsthand. We can fix a broken system in a way that actually works to get costs down, to get more people covered, to give people more choices, not in this plan, not in this atrocious plan which raises taxes, cuts Medicare, and takes away choices from the American people.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1963, which the clerk will report.

The assistant bill clerk read as follows:

A bill (S. 1963) to amend title 38, United States Code to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

The PRESIDING OFFICER. The Senator from Oklahoma.

AMENDMENT NO. 2785

Mr. COBURN. Mr. President, I call up amendment No. 2785.

The PRESIDING OFFICER. The clerk will report.

The assistant bill clerk read as follows:

The Senator from Oklahoma [Mr. COBURN] proposes an amendment numbered 2785.

Mr. COBURN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans)

On page 177, after line 10, add the following:

SEC. 1003. REQUIREMENT TO TRANSFER FUNDING FOR UNITED NATIONS CONTRIBUTIONS TO OFFSET COSTS OF PROVIDING ASSISTANCE TO FAMILY CAREGIVERS OF DISABLED VETERANS.

The Secretary of State shall transfer to the Secretary of Veterans Affairs, out of amounts appropriated or otherwise made available in a fiscal year for ''Contributions to International Organizations'' and ''Contributions for International Peacekeeping Activities'', such sums as the Secretaries jointly determine are necessary to carry out the provisions of this Act and the amendments made by this Act.

SEC. 1004. MODIFICATION OF ELIGIBILITY FOR FAMILY CAREGIVER ASSISTANCE.

(a) LIMITATION.—Section 1717A(b), as added by section 102 of this Act, is amended—

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

(2) in paragraph (2)(C), by striking the period at the end and inserting ''; and''; and

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

''(3) who, in the absence of personal care services, would require hospitalization, nursing home care, or other residential care.''.

(b) EXPANSION.—Such section 1717A(b) is further amended, in paragraph (1), by striking ''on or after September 11, 2001''.

Mr. COBURN. Inquiry, Mr. President. It is my understanding I am going to have 2 hours during this period of time under unanimous consent.

The PRESIDING OFFICER. The Senator is correct.

Mr. COBURN. I reserve the remainder of my time and yield to the chairman and ranking member.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I ask unanimous consent that I be permitted to use my time on the bill and my time on the amendment as necessary.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, as chairman of the Senate Committee on Veterans' Affairs, I had the honor of speaking at the World War II Memorial this past Veterans Day. As I stood there remembering my own comrades and their families, I thought of what the brave men and women in the service give up every day so we can enjoy the freedoms that come with American citizenship.

It is in that spirit that I urge this body to pass S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 without further delay.

The Nation's young veterans coming home from Iraq and Afghanistan have faced a new and terrifying kind of warfare, characterized by improvised explosive devices, sniper fire, and counterinsurgencies. Military medicine, fortunately, is saving more of these young servicemembers' lives than ever before.

In World War II, 30 percent of Americans injured in combat died. In Vietnam, 24 percent died. In the wars in Iraq and Afghanistan, about 10 percent of those injured have died.

As more of the catastrophically disabled are surviving to return home, more will require a lifetime of care. With our decision on S. 1963, we decide whether that care will be in their homes with the help of their family members or in institutions. If we want that care to be in the home, we need to help the families shoulder the burden of providing it.

During the prior administration, the President's Commission on Care for America's Returning Wounded Warriors—known as the Dole-Shalala Commission—found that 21 percent of Active Duty, 15 percent of Reserves, and 24 percent of retired or separated servicemembers who served in the Iraq or Afghanistan conflicts said friends or family members gave up a job to be with them or to act as their caregiver. By giving up a job, caregivers often give up health insurance, when they need it the most.

Studies also show family caregivers experience an increased likelihood of stress, depression, and mortality, compared to their noncaregiving peers.

Without a job, without health insurance, and in very stressful situations, family caregivers have worked to fulfill the Nation's obligation to care for its wounded warriors.

S. 1963 would give these caregivers health care, counseling, support, and a living stipend. The bill would provide caregivers with a stipend equal to what a home health agency would pay an employee to provide similar services. It would give the caregivers health care and make mental health services available to them. The bill also provides for respite care so caregivers can return to care for these veterans with renewed vigor and energy. It lets these young veterans return to their families and not to a nursing home.

While the caregiver program in this legislation will be limited at first to the veterans of the Iraq and Afghanistan wars, other provisions of the bill improve health care for all veterans.

There are provisions which make health care quality a priority, strengthen the credentialing and privileging requirements of VA health care providers, and require the VA to better oversee the quality of care provided in individual VA hospitals and clinics.

The bill will also improve care for homeless veterans, women veterans, veterans who live in rural areas, and veterans who suffer from mental illness.

About 131,000 veterans are homeless. S. 1963 would help these veterans obtain housing, pension benefits, and other supportive services. It would provide financial assistance to organizations that help homeless veterans.

Seventeen percent of servicemembers are now women. This legislation contains a number of provisions which are designed to improve the care and services provided to women veterans.

It would provide for the training of mental health professionals in the treatment of military sexual trauma and provide care for the newborn children of servicewomen. It would give women veterans a quality of care they have earned through their service to this country.

The bill also provides new assistance to veterans who live in rural areas. According to the VA, of the 8 million veterans enrolled in VA health care, about 3 million live in rural areas. This legislation would bring more services into rural communities through telemedicine and increased recruitment and retention incentives for health care providers. It also would increase the VA's ability to use volunteers at vet centers and create centers of excellence for rural health.

Finally, S. 1963 addresses the signature injuries of this war—PTSD and traumatic brain injury. According to a recent RAND report, one-third of veterans returning from Iraq and Afghanistan will develop post-traumatic stress disorder. Countless others will suffer from traumatic brain injury and face

significant problems in readjusting to life at home. Many studies have shown the importance of early intervention to the effective treatment of these invisible wounds.

This legislation contains provisions that allow Active-Duty military to seek mental health services at vet centers and increase access to care for veterans with traumatic brain injury.

Before concluding, I wish to share one of the many stories I have heard as I have worked to move this legislation through the Senate.

SGT Ted Wade sustained a severe brain injury after his humvee was hit by an improvised explosive device in Iraq. His right arm was completely severed above the elbow, and he also suffered a fractured leg, broken right foot, and visual impairment, among other injuries.

His wife Sarah Wade became his caregiver and a dedicated advocate for her husband, as well as for others who are providing caregiver services.

In testimony before the House Veterans' Affairs Committee earlier this year, Ms. Wade made the point that:

Young veterans with catastrophic injuries need support that will be around as long as the injuries they sustained in service to their country. Just like servicemembers need a team in the military to accomplish the mission, they need a team at home for the longer war.

I agree completely with that view. Veterans need all the support we can provide. We, as a country, can give them options that veterans of my generation never had. We can give them the option to really come home.

To those who are concerned about the cost of this legislation, I say we cannot now turn our back on the obligation to care for those who fought in the current wars. When we as a body vote to send American troops to war, we have promised to care for them when they return.

I firmly believe the cost of veterans benefits and services is a true cost of war and must be treated as such.

I ask that our colleagues accept no more delays and act on this important legislation.

Mr. President, I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I thank and congratulate the chairman of the VA Committee. This is important legislation in front of this body. It is my belief that this will move very quickly, as we can see from the short time agreement: one amendment—one amendment that I think is extremely important for all Members of the Senate to consider.

I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. This is actually the combination of two bills reported out of the Veterans' Affairs Committee this year, and it did enjoy bipartisan support.

The centerpiece of the legislation is the support it would provide to caregivers of severely injured veterans of current wars. The bill would provide counseling, support, living stipends, and health care for those caregivers.

As my colleagues know, family caregivers play an extremely important and, I might say, unique role in helping to meet the severely injured veterans' personal care needs. For some veterans, family members serve as their primary caregiver, some of whom have lost their jobs but, more importantly, have lost their health care as a result of that commitment to that family member.

As the chairman spoke about a servicemember he had remembered in this—Ted Wade is a North Carolinian—he made the same impression with me. I also think about caregivers Edgar and Beth Edmundson from North Carolina as well, the parents of Eric Edmundson, a severely injured veteran from Operation Iraqi Freedom. They have been caring for Eric since the day they took him out of the VA hospital—out of a VA hospital because the VA basically had come to the point where they said they could not improve Eric's life.

After Eric was injured on patrol along the Iraqi/Syrian border, he went into cardiac arrest while he was awaiting transport to Germany. It was in fact that cardiac arrest, that traumatic brain injury, that put Eric in a situation where he couldn't walk and he couldn't talk. As he lay in that long-term care provided by the Veterans' Administration, he got no better. He couldn't walk and he couldn't talk.

Eric's father stepped to the plate and immediately began researching all the options for Eric's treatment. Despite being told his son would not emerge from his vegetative state, Ed Edmundson pushed on. He sold his business, he cashed in his savings and retirement pay, all in an effort to provide Eric 24-hour care as a father.

Under his father's constant attention and relentless pursuit of new options, Eric received the treatment he needed. Without his dad's commitment, without the commitment of the rest of Eric's family—who basically dropped everything else important in life to focus on his needs—Eric would not be doing as well as he is today. I might say he walks and he talks and he continues to make progress every day because his most important caregivers, his parents, believed in him and they believed in what they could accomplish.

Let me tell you the rest of the story. Beth, Eric's mom, recently suffered a compound fracture of her ankle while caring for Eric's daughter Gracie. Because Beth and Ed have no health insurance, they are on the hook for $36,000 worth of medical bills. Had Eric chosen Beth, his mother, as his caregiver, and this legislation was in effect, we would have provided coverage for Beth to have health care coverage. I believe that is what this legislation is about—recognizing the individuals who make life-altering commitments to members of their family or servicemembers who, without that commitment, might not have the quality of life they have.

As I mentioned, assistance to caregivers is just one part of this bill. Other provisions would remove barriers to emergency care provided to veterans at non-VA facilities. It would expand health care services for women veterans, provide additional outreach to veterans in rural communities, provide additional improvements in mental health care services provided to veterans, enhance services to homeless veterans, improve the ability of VA to recruit and retain the needed health care professionals, authorize major medical facility construction projects, test a concept I introduced of providing veterans and their survivors with dental coverage, and much more.

This is a good bill. It is not perfect. It can be better. I urge my Senate colleagues to strongly consider supporting the amendment of Senator COBURN, and let me explain why.

When the committee passed this bill, we did not limit it to current veterans of current wars; we extended it to all veterans. Since it came out of committee in a bipartisan way, we have narrowed it down not to include all veterans. The amendment of Senator COBURN expands it to all veterans.

When the committee considered the caregiver bill, we considered it because we wanted to keep veterans out of nursing homes. That was the goal, to give them an alternative because the traditional role of the nursing long-term care facilities had not worked at improving the quality of care and the quality of life for these veterans. That was our goal.

Senator COBURN brings some definition to who is eligible for this based upon the fact that they would be headed toward a nursing home. We may tinker a little bit with the definition as to whether it is exclusive or totally as inclusive as we would like, but make no mistake, it is not different from the intent of the committee as to why the committee passed the caregivers act.

Let me mention one probably even more important piece of the amendment of Senator COBURN. It actually pays for what we are doing. We say the Secretary ''shall''—that means he has to implement everything in the caregiver bill. The amendment of Senator COBURN is going to say: You know what. We are going to take some money out of the funds that we pay to the U.N., and we are going to fund our veterans. I, for one, am tired of coming to the floor and spending money we don't have.

Why don't we take some of the money we have already appropriated and let's shift it? This is something novel for the Senate, but it is called prioritizing. Let's prioritize where the Federal investment should go. Let's make sure we pass the Caregivers and

Health Care Act. Let's make sure we pay for it with the Coburn amendment, and let's pull that money out of already-appropriated funds so we can not only look at our veterans, but we can look at our children and tell them this is a good bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I yield 10 minutes to the Senator from Washington, Mrs. MURRAY.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, last week many of us spent time back home celebrating our veterans and honoring the great sacrifices they made for our country. I had the opportunity to commemorate Veterans Day at the Tahoma National Cemetery in Kent, WA. It was truly an honor to stand with veterans and their families as we paid tribute to their service.

This recognition is important, it is certainly deserved, but it is not enough. We owe it to our veterans to make sure our commitment to them extends beyond Veterans Day and that they have access to the health care and services they have earned.

Growing up, I saw firsthand the many ways that military service can affect both veterans and their families. My father served in World War II. He was one of the first soldiers to land in Okinawa. He came home as a disabled veteran, and he was awarded the Purple Heart.

Like many soldiers of his generation, my dad did not talk about his experiences to us when he came home. In fact, we only learned about them by reading his journals after he passed away. That experience offered me a much larger lesson about veterans in general.

They are reluctant to call attention to their service. They are reluctant to ask for help. That is why we have to publicly recognize their sacrifices and contributions. It is up to us to make sure they get the recognition they have earned. Our veterans held up their end of the deal, now we have to hold up ours.

As a member of the Veterans' Affairs Committee, I am keenly aware that we have a lot of work to do for the men and women who served us. Not only must we continually strive to keep up our commitments to veterans from all wars, but we have to also respond to the new and very different issues facing veterans who are returning from Iraq and Afghanistan today, wars that are being fought under conditions that are very different from those in the past. That is precisely what the caregivers and veterans omnibus health bill that is before us today aims to do.

One of the changes we have seen in our veterans population recently is the growing number of women veterans who are seeking care at the VA. Today more women are serving in the military than ever before, and over the next 5 years, in fact, the number of women seeking care at the VA is expected to double. Not only are women answering the call to serve at unprecedented levels, they are also serving in a very different capacity.

In Iraq and Afghanistan, we have seen wars that do not have traditional front lines; therefore, all of our servicemembers, including women, find themselves on the front lines. So whether it is working at the check points or helping to search and clear neighborhoods or supporting supply convoys, women servicemembers face many of the same risks from IEDs and ambushes as their male counterparts.

But while the nature of their service has changed, the VA has been very slow to change the nature of the care they provide for these women when they return home. Today at the VA there is an insufficient number of doctors and staff with specific training and experience in women's health issues, and even the VA's own special studies have shown that women veterans are underserved. That is why included in this veterans health bill we are talking about today is a bill I introduced that will enable the VA to better understand and ultimately treat the unique needs of our female veterans. That bill authorizes several new programs and studies, including a comprehensive look at the barriers women currently face in accessing care through the VA. It is a study of women who have served in Iraq and Afghanistan to assess how those conflicts have affected their health.

There is a requirement that the VA implement a program to train and educate and certify VA mental health professionals to care for women with sexual trauma, and there is a pilot program that provides childcare to women veterans who are seeking mental health services at the VA.

This bill is the result of many discussions with women veterans on the unique and very personal problems they face when they return from war. Oftentimes after veterans meetings I held in which male veterans would speak freely about where they believed the VA wasn't meeting their needs, women veterans would approach me afterwards and walk up to me very quietly and whisper about the challenges they face.

Some of these women told me they don't view themselves as a veteran even though they served, and therefore they don't seek care at the VA. Others told me how they believed the lack of privacy at their local VA was very intimidating, or about being forced into a caregiving role that prevented them from seeking care as they would often have to struggle to find a babysitter just in order to keep an appointment. To me and to the bipartisan group of Senators who have cosponsored my women veterans bill, these barriers to care for women veterans were unacceptable.

As more women now begin to transition back home and step back into careers and their lives as moms and wives, the VA has to be there for them. This bill we are talking about today will help the VA modernize to meet their needs.

Another way this bill meets the changing needs of our veterans is in the area of assisting caregivers in the home. As we have all seen in Iraq and Afghanistan, medical advances have helped save the lives of servicemembers who, as we know, in previous conflicts would have perished from the severity of their wounds. But these modern miracles also mean many of those who have been cast catastrophically wounded need round-the-clock care when they come home. In many of our rural areas, where access to health care services is limited, the burden of providing care often falls on the families of those severely injured veterans.

For these family members, providing care for their loved ones becomes a full-time job. Oftentimes we hear they have to quit their current job, forfeiting not only their source of income but often their own health care insurance as well. That is a sacrifice that is far too great, especially for families who have already sacrificed so much. That is why this underlying bill provides those caregivers with health care, with counseling, with support, and, importantly, a stipend.

This bill also takes steps to provide dental insurance to our veterans and survivors and their dependents.

It improves mental health care services and eases the transition from active duty to civilian life. It expands outreach and technology to provide better care to veterans who live in rural areas. It initiates three programs to address homelessness among veterans at these especially difficult economic times.

This is a bill that is supported by numerous veterans service organizations, by the VA, and it is supported by many leading medical groups. It was passed in the Senate Veterans' Affairs Committee with broad bipartisan support, after hearings with health care experts and VA officials and veterans and their families. Like other omnibus veterans health care bills before us, bills that have often passed on the floor with overwhelming support, it puts veterans before politics. It is a bipartisan bill designed to move swiftly so its programs can be implemented swiftly. It is a bipartisan bill designed to make sure our veterans do not become political pawns. Yet we have faced a lot of delays in getting here. Those delays are all too common here in the Senate. We have seen bipartisan nominations stalled, funding bills slowed down to a crawl. It has taken us months to pass a simple extension of unemployment benefits for people who are out of work.

Providing for our veterans used to be one area where political affiliation and bipartisan bickering fell to the wayside. I hope those days are not behind us. Our aging veterans and the brave men and women who serve in Iraq and

Afghanistan need our help now. How we treat them at this critical time is going to send a signal to a generation of young people who today might be considering military service.

As I have said many times, it is so important that we keep our promise to veterans, the same promise Abraham Lincoln made to America's veterans 140 years ago, ''to care for the veteran who has borne in battle, his widow and his orphan.''

Our veterans have waited long enough for many of the improvements in this bill. We cannot ask them to wait any longer.

I spoke last week on the floor on the eve of Veterans Day urging colleagues to move quickly on this bill. I am so glad progress is now being made toward making that happen. As we wait to pass this bill, our promise goes unfulfilled to many of our Nation's heroes. I urge my colleagues to pass this bill quickly so we can get to the work of providing our veterans with the support and services they have earned.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, the reason we are having the debate now is because nobody would have the debate earlier. It is important for the American people. I don't have any opposition to veterans care. As a matter of fact, I support keeping our commitments. But as this thing wound out, on October 28 it came to the floor. Part of my amendment, when it actually came out of committee, was in the bill. It was taken out before it came to the floor, not by the members of the committee. It was taken out. But the very fact that we make an issue, because somebody wants to debate a bill and offer amendments on a bill, and then we are supposedly antiveteran because we think maybe we ought to pay for some things we do around here, so because we want to pay for it, we are cast aspersions that we don't want it to be debated. The worst thing that happens in this body is we pass bills that the American people have no idea about because we refuse to debate them.

I apologize to no one for having put a hold on this bill for a very good reason. The very good reason is this: Our veterans demonstrate courage greater than we ever demonstrate in this body. We ought to model that same courage. What is the courage I am talking about? The courage to make priorities, to make sure we keep those commitments. This bill, as it is written now, will cost $3.7 billion over the next 5 years. I think we ought to do that for these veterans. But I also think their sacrifice should not be in vain and stolen and paid for by their grandchildren. I believe we ought to pay for what we are going to do.

It is interesting that the Senator from Hawaii mentioned speaking at the World War II memorial. This bill, as written, excludes World War II veterans from the benefit. It excludes gulf war veterans from the benefit. What about them? Is the reason the other veterans, the Vietnam war veterans, the Korean war veterans were not included is because we thought we couldn't afford it? I think that is probably the reason. Which begs the question, if in fact we want to honor veterans, we ought to treat them the same, one, and we ought to have the courage to make hard choices about how we pay for it.

It is easy to charge this money to our grandkids. I have no doubt that is what we will end up doing. But the biggest threat facing our country today is not Islamic fascism and Islamic terrorism. The biggest threat facing the country today is the fact that every young child born today will encounter $400,000 worth of debt for benefits they will get nothing from. When we calculate the interest cost on that, by the time they are 25, they will have been carrying a debt load of $1,119,000.

As I look at my colleagues who want to do this but don't want to pay for it, I am bewildered to think that we can call and honor the courage and service of our veterans without taking some of the same courage to make some hard choices about funding of other things that are not nearly as important as our veterans. We can't do both. We can't continue down the road we are on. We can't continue to spend the money we are spending and borrowing, 43 cents of every dollar we spent this last year, borrowing it from our grandkids. It won't work. We will fail as a nation.

Look at President Obama's recent trip to China. What was the message that emerged? They are worried about us financially. They are worried about our deficit spending. Why are they worried? Because they own close to $1 trillion worth of our debt. They now impact our foreign policy decisions only by the fact that they own so much of our debt.

Can we continue to do this and have a free America? Can we continue to do this and our children have opportunity, at least to the level we have experienced? What are our veterans fighting for? Why did they put their bodies at risk, if it is not for a greater future for the country?

When we think about this past year—and it will be worse next year, it will be 44, 45 cents borrowed of every dollar we spend—do we not have an obligation to our grandchildren as well as our veterans? This isn't even a hard vote. Our entire contribution to the United Nations is wasted in the fraud of the peacekeeping we contribute to. We contribute 25 percent of the United Nations money, and we have reports and studies and leaked documents that show the vast majority of the money we put in the United Nations gets defrauded from the United Nations.

We are going to get to make a choice with this amendment. We will say we will treat all veterans the same, No. 1, and we are actually going to pay for it by saying it is a greater priority to take care of our veterans than to fund a corrupt, fraudulent peacekeeping force as run through the United Nations. That is what we are going to say.

If this amendment passes, it will send a wonderful signal to the United Nations to clean up their act. It will send a wonderful message to our children and grandchildren that we will finally start acting responsibly, and it will send a great message to veterans that we do care and we care enough to make sure the sacrifice they made will not be squandered by us not making hard choices.

We owe a lot to our veterans. The No. 1 thing we owe them is to make sure what they fought for and the future we have is secure in our children and grandchildren's generation. It is not secure today, based on the fiscal situation we find ourselves in.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mrs. MURRAY). The Senator from Hawaii.

Mr. AKAKA. Madam President, I yield 5 minutes to the Senator from Alaska, Mr. BEGICH.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. BEGICH. Madam President, I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. I am pleased we are now considering this bill. S. 1963 is comprehensive legislation that addresses many of the needs of our veterans and our Nation's heroes. The bill before us is a compilation of two earlier bills introduced by Chairman AKAKA to improve veterans health care and provide much needed benefits to their caregivers. I thank the chairman of the Veterans' Affairs Committee for his leadership on this bill and in committee. He understands the importance of providing the Department of Veterans Affairs the necessary tools and policies to serve the needs of veterans.

This legislation ensures that wounded warriors returning from Iraq and Afghanistan can receive care in their home by providing caregivers the necessary benefits to stay at home and care for them full time. This is especially important in rural States such as my State of Alaska where obtaining a caregiver from remote areas is extremely challenging. In those areas, families take care of their injured servicemembers. To further help rural veterans, this bill will allow servicemembers who are severely disabled or require emergency care to seek medical attention at non-VA facilities without being billed. For a veteran in one of the many remote villages of Alaska, this is especially important, for they already face many economic challenges.

The bill takes other steps to alleviate shortfalls in rural veterans health care. Telemedicine progam expansion, authority to collaborate with Indian Health Services and community organizations are just some of the additional efforts taken.

In addition to providing for caregivers and improving health care for

rural veterans, S. 1963 will finally require the Department of Veterans Affairs to identify and take action on shortfalls in health care for women veterans, mental health care, and outreach to homeless veterans.

Thirteen veteran organizations support S. 1963 as introduced by Chairman AKAKA. Unfortunately, one of my Senate colleagues disagrees with me and my other Senate colleagues and the 13 veteran organizations about this initiative and this bill and whom they serve. My Senate colleague has offered an amendment that almost doubles the cost. Although he claims the bill is discriminatory against veterans from previous wars, the expansion of rural, women's health, mental health, and homeless initiatives are not limited to any particular group of veterans. Additionally, my colleague's amendment offsets the cost of the bill by requiring the Department of State to transfer money to the Department of Veterans Affairs from the United Nations.

Sitting here for a few minutes listening to my colleague, I have to say a couple comments that are not written here. First, my colleague, who voted for the war supplementals that had no funding at all other than to make the cost there and no offset to them, sent people to war. When you do that, you have to also remember the costs associated over the long term. I wasn't here during those votes. I wasn't here when $1 trillion went to the richest of the rich for tax breaks that had not one dime of offset. I am paying for that. My son is paying for that. So it is interesting to hear this debate now.

We have to think long term. We have to think when we go to war, there are costs. If we don't fund them on the front end, we have to deal with them on the back end. That is what we are doing now.

I think his amendment is worthy to a certain degree, but I disagree with the funding source. Listening for the last 2 minutes as a new Member surprises me. My Senate colleague is forcing us to make an inappropriate choice with this amendment that will cost us more in the long run. He is asking us to choose between providing for veterans and maintaining America's essential role in the world. His amendment pays for this bill by breaking U.S. international obligations. If his amendment passes, it would threaten ongoing peace operations in Haiti, Sudan, and Lebanon.

By breaking our international promises, we undermine our national security by opening opportunities for instability, conflict, and strife. If there is instability, conflict, and strife, then it means more troops will have to serve and more come home wounded. Then we will have to pass another bill to pay for those troops and their care when they return.

U.N. peacekeeping operations are eight times less expensive than U.S. forces, according to a GAO study in 2006. If my Senate colleague were truly concerned about costs, he would not have chosen, as I mentioned, to cut accounts, which undermines our national security and breaks international obligations. His amendment just does not make sense. It is fiscally and politically irresponsible. I urge him to withdraw this amendment and to remember he has voted for billions of dollars in funding that was not offset for these wars. Funding the wars is just as important as fulfilling our promises to our veterans when they return.

So many issues facing our veterans today are addressed in S. 1963. Passage of this legislation and its enactment into law will improve and increase services for our veterans and acknowledge the sacrifice of their caregivers.

I urge my colleagues to vote no on the amendment and support passage of S. 1963 as it has been introduced.

Again, I thank the chairman, Senator AKAKA, for his unwavering support and advocacy for our veterans.

Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. AKAKA. Madam President, I yield 3 minutes to the Senator from Montana, Mr. TESTER.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. TESTER. Thank you, Madam President, and I thank Chairman AKAKA.

Madam President, I rise this morning to urge the Senate to pass the Caregivers and Veterans Omnibus Health Services Act of 2009. Chairman AKAKA has done a great job of explaining the particulars of this bill. I thank him and Senator BURR for their leadership in our committee.

I could also echo Senator AKAKA in explaining the reasons to vote for better health care for this county's veterans. But, instead, I am going to boil it down to one reason. Madam President, we promised it—we promised it—to all the men and women who served in our military. We promised it, just as we promised our troops the resources they need when they are in battle. This is not a vote about politics or partisanship; it is about living up to the pledge we made to all our veterans.

Montana is a rural State, which means that all 100,000 veterans there are rural veterans. Many of them live in frontier communities. Sadly, that means they have a tougher time getting the health care they have earned. Many of them still have to pay out-of-pocket travel expenses to get to a VA hospital for their health care. According to some studies, veterans who live in rural America do not live as long as veterans who live in urban places. That is not only sad, it is disgraceful, and it is unacceptable.

This bill contains provisions I included with the help of rural veterans and veterans service organizations in Montana. A vote for this bill is a vote to give veterans in rural America and frontier communities better access to health care. A vote for this bill will lock in an acceptable VA mileage reimbursement rate for disabled veterans who have long distances to travel to get to a VA hospital. A vote for this bill will authorize the VA to award grants to veterans service organizations that drive veterans to their medical appointments. In a place such as Montana, we would be in pretty tough shape without the dozens of volunteers who make that sort of thing happen. A vote for this bill will also improve health care in Indian country, and it will improve mental health care for rural veterans.

Last week, over Veterans Day, I had the honor of attending events across Montana. I had the opportunity to say thank you to our veterans, as we should do every day. A lot of veterans to whom I spoke last week made it clear—made it clear to me—we still have a lot of work to do to live up to the promises we have made to our fighting men and women.

This legislation is not the be-all and end-all, but it is a big step forward that is the result of putting politics aside and working together to do right by all of the men and women who have served our country.

Passing this legislation is living up to a promise. It is common sense. That is why I urge my colleagues to support it.

With that, Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Oklahoma.

Mr. COBURN. Madam President, may I inquire how much time I have remaining?

The PRESIDING OFFICER. The Senator from Oklahoma controls 112 minutes.

Mr. COBURN. Thank you, Madam President.

I want to go back to the start of this again. The American people need to know what a hold is. What is a hold? A hold says that a bill is trying to go through the Senate without debate, without discussion, that by unanimous consent everybody agrees we ought to pass a bill the way it is. Unfortunately, 70 percent of the bills that go through the Senate pass that way. The American people get to hear no debate, get to have no knowledge about what is in the bill, whether there is controversy about what is in it. As a matter of fact, they do not know that the bill on the floor is actually different from the bill that passed out of committee. It has been modified, not with the vote of the committee but with the direction of the chairman only.

So the purpose of our holds is either you are against the bill—and I have no secret holds. Everybody here knows that. When I hold a bill, everybody knows the bills I hold, and I give a reason for why I hold them. I do not hold them sheepishly. The purpose for a hold is to develop debate, to have the very discussion we are having on the floor.

This bill was filed October 28. It was brought to the floor the week before

last without the ability to amend it, debate it, or discuss it. So the reason we are here today is so we can do just that.

I have stated numerous times—I have stated it to the chairman of the committee and the ranking member of the committee and others—I do not oppose—as a matter of fact, I am for providing for our veterans. What I am opposed to is us sinking our grandchildren in debt.

The Senator from Alaska makes the claim or insinuates that I was here when the tax cuts came through. I was not. I believe when you do tax cuts you match them with spending cuts.

There is $350 billion a year in waste, fraud, and abuse that goes through this government every year. Not one amendment out of over 600 that have been offered has been agreed to by this body to eliminate some of that waste—not one.

Everybody who has spoken against this amendment or for this bill, with the exception of Senator BURR, has a 100-percent voting record for spending money. Not once do they vote against any spending bills, not once since I have been in the Senate—5 years. Not one of those who are opposed to paying for this has said: I see something wrong with this spending bill. It is not a priority. We ought to cut it. Therefore, I am not going to vote for it.

I have had criticism because the first year I was here I actually voted for a war supplemental. But at that time, we had a deficit of $110 billion, not $1.4 trillion. At that time, we had an economy that was growing, not an economy on its back. At that time, we had not totally mortgaged our children's future.

It is time for all of us to change. It is time for all of us to make the same decisions everybody outside of Washington has to make every day, which means you have to make a choice. You get to make a choice on what is a priority and what is not. For, you see, our body, the supposed most deliberative body in the world, has a bias. The bias is this: Offend no one. Offend no one. How do you do that? How do you offend no one? You offend no one by taking the government credit card out of your pocket and putting it into the machine and saying: We do not have to make those hard choices. We are not going to offend anybody by cutting programs. We are not going to offend anybody with the $50 billion a year of waste at the Pentagon. The fact is, 2 years ago the Pentagon paid out performance bonuses of over $6 billion to companies that did not meet the performance requirements.

Sadly, not one American, not the Federal Government, got any of that money back. None of it came back because the other side of the story is, we fail to do oversight. We fail to do the hard work that does not give you a headline. That is very hard work to hold the executive branch and agencies accountable. So our veterans do sacrifice.

I am for the Caregivers Act. I am for us doing all these things. But I am only for them if, in fact, we will start making the same hard choices our veterans make, the same hard choices everybody else in this country makes when it comes to making a decision about the future.

You see, a lot of people in our country today are underwater on their mortgages. They are underwater on their mortgages. Guess who else is. We are as a nation. We are underwater. Let me show with this chart, for example, what the financial situation is with our country.

Medicare is broke. Part A will run out of money in 2017. We have 50 million baby boomers—I am one of them—who are going into Medicare in the next 8 to 10 years. So not only is the cost per Medicare patient going to go up, but we are going to add 50 million to it. It is broke.

Medicaid. It is broke. It comes out of your general tax revenue. But the States are broke over their share of Medicaid.

The census. It is broke. It is going to cost 2½ times what the last one did. It is total mismanagement by the Federal Government.

Fanny Mae and Freddie Mac—broke to the tune of $200 billion of your money, each one of them; $400 billion that your kids get to pay back, your grandkids. They do not get the opportunities because they are both broke. We have done such a wonderful job.

Social Security. It is the easiest to fix, but it is essentially broke because we have stolen $2.6 trillion from it. And then we are not being honest with the American public about what our true deficit is because when I said a minute ago that our deficit was $1.43 trillion, that is not true. That is Enron accounting. That is Washington accounting. The real deficit is well over $1.5 trillion because we stole more money from Social Security. Guess what. Next year, for the first time in the history of Social Security, more money will be paid out than will be paid in. For the first time, it runs in the red next year. We owe money, so technically it is not broke yet—until some of that $2-plus trillion goes back into it—but it is essentially broke.

How about the post office? They just announced their loss for this year. They are going to have a bigger loss next year. It is broke.

Cash for clunkers. That was broke when it started.

The highway trust fund. It is broke. We do not have enough money for what we are obligated to pay out. It is broke.

Now we are talking about government-run health care? A $2.5 trillion program? That is what the real number is on it when you get the Enron accounting out of the bill that Senator REID introduced last night—$2.5 trillion.

And now we are saying we do not have the courage to pay to take care of our veterans. I do not think the American people are going to tolerate this much longer, nor do I think they should tolerate it—that we will continue to steal the opportunity and future of our children.

I think the Senator from Alaska can be forgiven for not knowing all the abuse, fraud, and waste in the U.N. because in every country he mentioned, U.N. peacekeepers have been accused of rape and pillaging the very people they were supposed to have been protecting. In every country he mentioned, U.N. peacekeepers we paid for are raping the very citizens they are supposed to be protecting. Yet we do not have the courage to say: Time out. We are not sending you any more money until you clean up the mess. No, we are not going to do that. We are not about to do that. What we are going to do is we are going to say we will take the money for the veterans from our grandchildren and we will not make the hard choice. I think it would be a wonderful message to send to the United Nations that maybe they ought to start being transparent about where the money goes. Do you realize nobody can know where the money goes? You don't get to know. I, as a Senator, don't get to know. The President pro tempore doesn't get to know where the money goes. Yet your country puts $5 billion a year into that and you have no idea. The only way we find out is occasional leaks.

By the way, of all those U.N. peacekeepers who have raped and pillaged, not one of them has been convicted. Not one of the agencies, in terms of their eight programs that have been incompetent and wasted money, have been convicted. They are immune to conviction. The waste, fraud, and abuse of this country is only exceeded by one organization, and that is the United Nations. Yet we don't have the courage because the State Department is against this amendment, and they sent a letter outlining why they are against it. I am going to put into the RECORD why they are wrong. I ask unanimous consent that at the end of these remarks, my rebuttal statement in response be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. COBURN. The State Department Bureau of Legislative Affairs opposes this amendment. It lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment. Many of the programs and activities the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities.

Let's take the recent elections in Afghanistan. The United Nations cannot account for tens of millions of dollars provided to the Afghan election commission, according to two U.N. audits—these are confidential; they weren't released; we just happened to be fortunate enough to have people who would give them to us—and interviews with

current and former senior diplomats. The Afghan election commission, with over $20 million in U.N. funding and hundreds of millions of dollars in U.S. funding, facilitated and helped mass election fraud and operated ghost polling places.

Should we keep sending them money for incompetence, waste, and fraud?

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan.

Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.

This is a deputy to the senior U.N. official in Afghanistan. He was fired last month. He protested the fraud and he got fired by the U.N., that wonderfully competent organization.

As of April 2009, the U.N. had spent $72.4 million supporting the electoral commission, with $56.7 million of that money coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for that election.

In one instance, the United Nations Development Programme paid $6.8 million for transportation costs in areas where no U.N. officials were present. We paid transportation costs, but no U.N. officials were present. Why did we pay it? Where did that money go? Where is the money?

Overall, the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

In other words, it is there, they send it out, they don't have any idea, but you can bet well-connected people at the U.N. are making millions off U.S. dollars.

How about the monitoring of nuclear programs in North Korea and Iran? In 2002, the North Korean Government used United Nations Development Programme money—UNDP money or aid—to purchase—this is aid for them for development from the U.N.—they purchased conventional arms and ballistic missiles. With money we gave the U.N., the U.N. turns around, gives it to North Korea, and they buy missiles and arms. There is a real problem at the U.N. We will not face up to it.

It also transferred millions of dollars in cash to the Government of North Korea, with no oversight on how the money was spent—no oversight, just handed them millions of dollars in cash.

In September 2009, North Korea announced to the United Nations Security Council that it was almost complete in weaponizing nuclear materials from its nuclear reactor. Last week, North Korea announced the processing was complete.

We helped finance it through the United Nations. We helped finance it through the United Nations.

As of this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

We don't know how much U.N. money has gone in there yet, but I promise I will try to find out. But I can guarantee that millions of our dollars have been wasted that could pay for our veterans or we can borrow it from our children.

U.N. contribution: Funding 17 U.N. peacekeeping operations, including those in Haiti, Liberia, Lebanon, Darfur, and the Democratic Republic of Congo.

U.N. peacekeeping operations are plagued by rape and sexual exploitation of refugees. From 1994 forward, 68 separate instances of rape, prostitution, and pedophilia—68 separate times—and we pay half the U.N. peacekeeping costs. We don't manage the money; the U.N. manages the money.

What would happen if U.S. troops were doing that? Yet we have no control.

In 2006, reported BBC News: Peacekeepers in Haiti and Liberia were involved in exploitation of refugees. You can read that in the BBC News of November 30, 2006, if you want to look it up.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past 3 years, ranging from rape to assault on minors. Not one of them has been prosecuted, not one.

Just this month, Human Rights Watch reported that Congolese Armed Forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo, have brutally killed hundreds of civilians and committed widespread rape in the past 3 months in a military operation backed by the United Nations. That is this month. Yet we continue to send billions of dollars every year to the United Nations.

Mr. DURBIN. Madam President, will the Senator from Oklahoma yield for a procedural question?

Mr. COBURN. I will be happy to yield for a procedural question.

Mr. DURBIN. I am interested in speaking on behalf of the bill, and I know the Senator has time allocated under the unanimous consent request. I wish to ask him at his convenience if he has a time when he would be able to yield to this side or is he going to speak and use all his time?

Mr. COBURN. I do not plan on consuming all of it at this time. I have about 10 or 15 minutes more to go, and I will be happy—is the Senator wanting time?

Mr. DURBIN. Could I ask unanimous consent that when the Senator breaks or prepares to yield the floor, at least temporarily, that I be recognized next?

Mr. COBURN. I have no objection to that.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. I thank the Senator.

Mr. COBURN. Going back to the Congolese, most of the victims were women, children, and the elderly. Some were decapitated. Remember, these are U.N. peacekeeping forces—peacekeeping. Others were chopped to death by machete, beaten to death with clubs as they tried to flee.

They may not have been actual U.N. officers, but the U.N. was supplying all the logistics, all the transportation for this group of people. Where is the oversight?

U.N. contribution: Compiling forecasts of global agriculture production and identifying areas of likely famine and the risk of severe hunger, to facilitate food assistance. We make a contribution to the U.N. The Food and Agriculture Organization is currently hosting a U.N. conference, a food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe who has literally destroyed his Nation, which used to be the bread basket of Africa and which is now dependent on food imports. We are helping to pay for President Mugabe—who can't travel hardly anywhere else in the world because he is such a rogue dictator—we are sponsoring, through our dollars, meetings where he is the headline speaker.

The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously rebuffed the United Nations' appeal for commitments of billions of dollars in yearly aid to develop agriculture in poor nations.

It is not because they don't care about people having problems with food; it is they recognize the U.N. is ineffective at doing that and they are not going to commit more money, but we continue to commit more money.

The U.N. Environment Programme spends $1 billion a year—20 percent of it our money—on global warming and its effect on agriculture.

The U.N. has coordinated efforts by the global shipping industry and governments to prevent and respond to acts of piracy on the high seas.

It was totally ineffective. Do you know why we decreased the amount of piracy on the high seas? It is because of Task Force 51, which was formed by the U.S. Navy because the United Nations was totally ineffective in accomplishing that purpose.

I could go on and on. But the fact is, the United Nations is not only morally bankrupt in its leadership and efficiency, it is filled with fraud, waste, and, as noted, tremendous acts of violence through the peacekeeping armies it sends throughout the world. Yet we are going to have people say we shouldn't take some of that money away. We are not taking all the money away with this amendment anyway; we are just taking a small portion to pay for our bill.

We are going to have people actually vote to continue to do these things, instead of taking care of our veterans and not steal it from our children.

I heard Senator TESTER speak about the wonderful things in this bill to help people who drive to VA clinics and VA hospitals. There is a better idea. If a veteran is deserving of care, give him a card. Let them go wherever they want.

Why should they have to drive 160 miles, when they can get the care right down the street from somebody they trust and they know. But instead we say: We are going to promise you health care, but you can only get it here. Real freedom for our veterans—real health care for our veterans is to honor their commitment by saying: Here is your card, you served our Nation, go get your health care wherever you want. If you want to get it next door or if you want to go to the M.D. Anderson or Mayo Clinic, you can. You can go wherever you want because we are going to honor your commitment.

I recognize our VA hospitals have done a magnificent job in improving their care, but I will tell you the test for the VA hospital system is this: Go ask any doctor coming out of training who experienced part of their time in a VA hospital and ask them to choose for their family: Do you want your family treated at a VA hospital or somewhere else where you trained? Nary a one will pick a VA hospital because the care isn't as good. It is better, and it is getting better all the time, but it is not as good. So we are saying to veterans: Here is where you have to go, when what we should say is: Thank you for your service. Here is what we owe you. Go get care wherever you want to get it or wherever you think you can get the best treatment.

On prosthetics, the VA is the best in the world. Nobody compares. On posttraumatic stress disorder, they are the best in the world. Nobody can compare. They are underfunded in those areas. This bill is right on that. But the real commitment is to give the choice. The veteran fought for freedom. Give them the choice, the freedom to choose what they want for them.

Why is it important we change how the Senate operates in terms of making hard decisions? The reason it is important is there are millions of these little girls out there. I have five of them, five grandkids just like her. She has a little sign around her neck. She says: ''I am already $38,375 in debt and I only own a dollhouse.'' Of course, when you divide up the $12 trillion which we passed this week in directly owned debt; it doesn't count the billions—I mean the trillions—we have borrowed from Social Security and the other trust funds, such as the waterway trust fund and all these other organizations we have stolen from, it doesn't include that. But that is for every man, woman, and child in this country. It is over $30,000 now, this year. I think when you look at her, you have to say, certainly, we ought to be making some changes. By the way, between now and 2019, that number goes to over $96,000 per man, woman, and child. But she is a child. This doesn't apply to veterans, but it applies to almost everything else we are doing.

This is what Thomas Jefferson said:

The democracy will cease to exist when you take away from those who are willing to work to give to those who would not.

If you think about what is happening in our country right now and how things are being shifted, what we are doing is, we are on the cusp of a dramatic change in our country in terms of balance. This huge bill, which I will talk about later, is a major move in that direction. Senator BYRD and I were talking this morning about this. In this bill is a 5-percent tax on cosmetic surgery. Just the day before yesterday, the U.S. Preventive Task Force Services recommended—because it is not cost effective—that women under 50 not get mammograms unless they have risk factors. You tell that to the thousands of women under 50 who were diagnosed with breast cancer last year with a mammogram. Tell them it is not cost effective. But also in this bill is a 5-percent tax on breast reconstruction surgery after they have had a mastectomy. They are going to tax having their breasts rebuilt after their breasts have been taken off because it is an ''elective'' plastic surgery. It is an elective cosmetic surgery. We are going to have a tax on it because we have taxed elective cosmetic surgery.

We are in trouble as a nation because we have taken our eye off the ball. I see the majority whip is back. I told him I would be happy to yield. At this time, I will reserve the remainder of my time and yield the floor to the majority whip.

EXHIBIT 1

REBUTTAL OF STATE DEPARTMENT TALKING POINTS ON COBURN AMENDMENT 2785

The State Department Bureau of Legislative Affairs opposes the Coburn amendment to S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 1963). In its formal opposition, it lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment.

Many of the programs and activities that the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities. (Their document is after the rebuttal).

Below is a list of those ''accomplishments'' and facts that should be considered.

U.N. Contribution: Facilitating and holding elections in Afghanistan and Iraq (U.N. Secretariat).

Response: The United Nations cannot account for tens of millions of dollars provided to the troubled Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of millions in U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. ''Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.'' Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired last month after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 million supporting the electoral commission with $56.7 million coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for the election.

In one instance, the United Nations Development Program paid $6.8 million for transportation costs in areas where no U.N. officials were present. Overall the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

U.N. Contribution: Monitoring nuclear programs in North Korea and Iran.

Response: In 2002, the North Korean government used United Nations Development Program, UNDP, aid to purchase conventional arms, ballistic missiles. It also transferred millions of dollars in cash to the government of North Korea with no oversight of how the money was spent.

In September 2009, North Korea announced to the United Nations Security Council that it was almost complete in ''weaponizing'' nuclear materials from its nuclear reactor. Last week, North Korea announced the processing was complete.

As of this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

U.N. Contribution: Funding 17 U.N. Peacekeeping Operations, including those in Haiti, Liberia, Lebanon, Darfur and the Democratic Republic of Congo.

Response: U.N. Peacekeeping operations plagued by rape and sexual exploitation of refugees—In 1994, a draft U.N. report was leaked detailing how peacekeepers in Morocco, Pakistan, Uruguay, Tunis, South Africa and Nepal were involved in 68 cases of rape, prostitution and pedophilia. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, it was reported that peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted.

Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beaten to death with clubs, or shot as they tried to flee.

The U.N. peacekeeping mission provides substantial operational and logistics support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanda, Congolese army soldiers decapitated four young men, cut off their arms, and then threw their heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12-year-old girl, later killing four of them.

The U.S. now pays 27 percent of all U.N. peacekeeping operations. Reducing our contribution to these wasteful efforts could help ensure that U.N. peacekeepers are not funding widespread rape and exploitation of refugees.

U.N. Contribution: Compiling forecasts of global agricultural production, identifying areas of likely famine and risk of severe hunger, to facilitate emergency food assistance (FAO).

Response: The FAO (Food and Agriculture Organization) is currently hosting a U.N. food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe. Mugabe is barred from travel to most Western countries because of his atrocious human rights record, but receives an exception for U.N. sponsored events. No G–8 leader attended the event save the Prime Minister of Italy, the host nation.

''The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously rebuffed the United Nations' appeal for commitments of billions of dollars in yearly aid to develop agriculture in poor nations.''

The U.N. Environment Program spends over $1 billion annually on global warming initiatives (and weighs in on its effect on agriculture) but there is almost no auditing or oversight being conducted. The U.N. Environment program has one auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified in UNEP's work.

U.N. Contribution: Coordinating tsunami and earthquake relief projects in Indonesia and Pakistan (U.N. Secretariat/OCHA).

Response: The United States is the top contributor to the Office for the Coordination of Humanitarian Affairs (OCHA) for funding disasters after they occur. In addition to billions in supplemental funding (above and beyond normal U.N. contributions) the United States military expends tremendous resources in money and personnel to be the first response for disaster aid.

U.N. Contribution: Coordinating efforts by global shipping industry and governments to prevent and respond to acts of piracy on the high seas (IMO).

Response: The key deterrence factor in combating piracy in Somalia is the creation of Task Force 151, which was formed by the United States Navy.

The United Nations has pushed the U.S. to ratify the United Nations Convention on the Law of the Sea. However, the convention has no way to address piracy issues coming from failed states such as Somalia. Fighting piracy is being conducted by individual states patrolling their own waters and working with other nations to protect sea lanes that are in their national interest.

U.N. Contribution: Creating and maintaining systems to protect the intellectual property rights of American entrepreneurs (WIPO).

Response: Until last year, the Director General of the World Intellectual Property Organization, WIPO, was run by Dr. Kamil Idris, who was appointed to that position in 1997. According to an internal investigation, he falsified his U.N. personnel file to drop nine years from his age—making it possible to extend his time at WIPO and to extend his ability to obtain a lucrative benefit package, including a possible payout of more than $500,000. The scandal was first reported in a leaked U.S. State Department cable authored by former Secretary of State Rice. The cable also states that this official is suspected of using U.N. funds for personal items such as the construction of a swimming pool at his residence.

WIPO has also been criticized for its working culture under Dr. Idris's leadership, with a report by accounting firm Price Waterhouse Coopers citing high levels of absenteeism, incompetence and inadequate disciplinary measures.

U.N. Contribution: Enabling the delivery of mail around the world (UPU).

Response: The Universal Postal Union, UPU, which coordinates international postal policies among nations, was created in 1874 (renamed in 1878). Its creation predates the United Nations by 72 years.

UNITED NATIONS FUNDING

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009 (S. 1963)

Senate Amendment: Senate Amendment No. 2758 submitted by Senator Coburn to S. 1963. To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans.

Department Position: Oppose amendment.

Talking Points: U.N. assessed contributions fund a wide range of U.N. activities that support high U.S. foreign policy priorities. Some examples include:

Facilitating and holding elections in Afghanistan and Iraq (U.N. Secretariat);

Monitoring nuclear programs in North Korea and Iran (IAEA);

Funding 17 U.N. Peacekeeping Operations, including those in Haiti, Liberia, Lebanon, Darfur and the Democratic Republic of Congo;

Compiling forecasts of global agricultural production, identifying areas of likely famine and risk of severe hunger, to facilitate emergency food assistance (FAO);

Coordinating tsunami and earthquake relief projects in Indonesia and Pakistan (U.N. Secretariat/OCHA);

Detecting outbreaks of avian flu and H1N1 and other infectious diseases and defending against a world pandemic (WHO, FAO);

Creating and maintaining systems to protect the intellectual property rights of American entrepreneurs (WIPO);

Enabling the delivery of mail around the world (UPU);

Coordinating international aviation safety standards (ICAO);

Coordinating global use of electronic communications frequencies to ensure essential global telecommunications function smoothly (ITU);

Coordinating efforts by global shipping industry and governments to prevent and respond to acts of piracy on the high seas (IMO).

Furthermore, the President has stated his commitment to paying U.S. dues to international organizations in full.

As Ambassador Rice has said, we meet our obligations. As we call upon others to help reform and strengthen the U.N., the United States must do its part—and pay its bills. Our dues to the United Nations and other international organizations are treaty obligations, and we are committed to working with Congress to pay them in full.

With the support of Congress, the U.S. has just cleared our arrears which accumulated over the past decade. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations.

Going into arrears undermines U.S. credibility, particularly on matters dealing with budget, finance, and management of IOs, and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy. Arrears also have a real impact on the organizations, making it more difficult for these organizations to manage cash flows and execute budgets, and thus accomplish their missions.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank my friend and colleague from Oklahoma. Although we disagree on many things, we also agree on many things. We work together and will continue to do so.

We have a difference of opinion on the matter before us. This bill, S. 1963, is the most important piece of veterans legislation this year for several reasons. I congratulate Chairman AKAKA and Ranking Member BURR for bringing this matter to the Senate with a unanimous vote in committee, with both Democrats and Republicans supporting it, and for good reason.

In addition to the provision that was part of an earlier bill I had introduced, there is dramatic change in the law to help women veterans. More and more returning veterans from Iraq and Afghanistan and around the world need special care. Unfortunately, the VA system wasn't providing that care as we believed it should. This bill takes care of that. It is the most dramatic expansion for women veterans and their health needs we have seen.

The same is true for rural health care. I know that. The Presiding Officer is from downstate Illinois, as I am, and he knows the Marion VA Center is a critical part of the treatment of veterans in southern Illinois and the surrounding States. Literally thousands of hard-working people there provide care for veterans, which they desperately need, close to their homes. This bill addresses the enhancement and improvement of rural care for veterans.

The same is true for mental health issues. It is an excellent bill. The part of the bill that is near and dear to me relates to caregivers assistance. It relates to the fact that many veterans who come home are not in institutional settings, not in a hospital, not in a convalescent center; they are home. But they survive every day because of the loving care of a member of their family—a wife, a husband, a mother, a father, a sister, or a brother—who gets up every morning and worries about that veteran and makes sure that veteran receives the medical care needed to survive another day. They are in the setting of their home where they feel secure and happy.

Great sacrifice takes place. I cannot tell you exactly how many of these caregivers there may be. Estimates range as high as 6,000 or 8,000. I have met some of them, and I know them personally. I have heard their stories. They are heroic—just as heroic as the veteran who needs their care. They are literally giving their lives to keep that veteran alive, healthy and happy, at great personal sacrifice. Many times they cannot go to work. Many times they give up a business because they want to stay home with that husband they love.

A young woman came into my office the other day who is moving from North Carolina back to the Chicagoland area after more than 5½ years. She has been the caregiver for her husband who was the victim of a traumatic brain injury in Iraq. For this young woman, who is in her thirties, it is an amazing show of love and sacrifice on her part.

We have also spoken of the family in North Carolina we know very well—the

family of Eric Edmundson, a young soldier who was the victim of a traumatic brain injury. He is alive today—I can say this without contradiction—because his dad quit his job, sold his business, and cashed in the value of his home. With his wife, they moved in to take care of their son and little granddaughter. That is the most loving family I can remember seeing, and they are doing it for the son they love, but they are doing it, as well, for a veteran who served our country.

The purpose of this bill is to give these caregivers a helping hand and the medical training they need so they can do what is necessary to keep that veteran alive and as well as possible, improving if possible. It is also to give them a respite maybe for a week or two each year so they can go on vacation and have a visiting nurse or someone who will come and provide assistance. They need that with the stress and burden they are carrying. That needs to be lifted—at least temporarily—so they can recharge their battery and come home and be dedicated once again.

In the discretion of the Veterans' Administration, it can give a monthly stipend or health care as well. The first thing the Edmundson family found when they sold the business was that they couldn't afford to buy health insurance. Mom and dad are taking care of their son under the care of the Veterans' Administration, and they have no health insurance.

We are trying to find a way to provide health insurance for these caregivers. In my mind, it is simply fair and right that we would do this. That is why I thank Senator AKAKA and Senator BURR for including it in this bill.

I also want to address the issue before us, the pending amendment by the Senator from Oklahoma. The Senator from Oklahoma has come to the Senate floor several times and expressed his opposition to this bill, primarily for budgetary reasons. I understand that. But I say to him I was worried this day would come. I was worried the day would come when the war, which we paid for by borrowing money, would generate victims and veterans who needed care, and when it came time to give them the care many of the people who voted to fund the war by going into debt would say: But we can't help the veterans unless we pay for it.

In my mind, it is all the same. If we vote to go to war, we vote to accept the consequences of war. That means an obligation that we have to these veterans. It is a solemn promise we gave them. We said to these men and women if they would hold up their hand, take an oath to defend the United States and risk their lives, we would stand by them when they come home. If they are injured, we will be there. If their family is disadvantaged, we will do our best to help them too. I think that is part of our solemn obligation to these veterans.

Now the question is raised as to whether we can afford to do that, unless we come up with a sum of money to pay for it at this moment. I say to the Senator from Oklahoma, and those who take his position, if we paid for this war to start with by borrowing money, how can we turn our backs on the veterans and caregivers who keep them alive arguing that it is simple budgetary justice? It is just not. It doesn't track. I don't believe those two approaches are acceptable.

Also, the Senator from Oklahoma does two things in this amendment I wish we could do—one I wish we could do. I have talked to him about it on the Senate floor—and that is to expand coverage for caregivers of those who served before 9/11. I would like to do that. Currently, we believe there are about 2,000 caregivers who would qualify for this caregiver amendment, this demonstration project. If we expand it to all veterans caregivers, the number rises to over 52,000. It is a just thing to do. It is something we may ultimately do. But, clearly, if we are going to make that commitment, it is a dramatically larger commitment than this demonstration project, this bill for those who suffered serious injuries since 9/11. To increase the scope of it from 2,000 caregivers to 52,000 caregivers is to increase the cost of it dramatically. That is something we have to measure and decide at some point—whether we want to do that.

I will work with the Senator from Oklahoma to expand that. I think all veterans' caregivers deserve this. I hope we can prove with this approach that it is a reasonable thing to do—that keeping these veterans home where they want to be, in a safe, happy surrounding, is not only right but it is cheaper than institutionalization.

The second part of Senator COBURN's amendment related to this provision says the money would be available for caregivers if the veteran would otherwise be institutionalized. I think that may be drawing a line that is too harsh. I think there are those who need the help of a caregiver but may not technically need to be institutionalized. I think those who are suffering from post-traumatic stress disorder, a traumatic brain injury with seizures—to say they need to be institutionalized may be overstating. To say they need the help of a caregiver and then move forward to treatment, I understand that may happen. On the one hand, I think the Senator from Oklahoma expanded this bill from 2,000 to 52,000. On the other hand, he draws a line on institutionalization that may go too far. I think what we ought to do in this demonstration project is give the VA the authority to measure this and see what is appropriate. I think there are so many individual cases that, when we generalize like this, it is a mistake.

The Senator from Oklahoma believes the money to pay for this should come from the money set up for international peacekeeping through the U.N. I will not stand here in defense of every decision made by the U.N. It is hard to do that. We make mistakes in the United States, and the U.N. does too. They have been caught and so have we. I want to make sure money is not wasted. We should be vigilant, whether it is money being spent by our government or agencies we support. I worry that the proposal before us by Senator COBURN is going to cut back on international peacekeeping in areas of the world where I think it is critical.

I visited the Democratic Republic of Congo 2 years ago with Senator BROWNBACK of Kansas. But for the U.N. peacekeeping forces there, the massacres of innocent people would go unchecked.

This has been going on for over a decade. During this period of time, innocent men, women, and children have been literally hacked to death and killed. The international peacekeepers make a difference there. They make a difference in Haiti where I visited twice and have seen firsthand the degraded poverty in our own hemisphere and, unfortunately, the fact they are on the verge of violence almost every moment.

I also think it is a mistake for us to cut back on those international agencies that monitor the spread of nuclear weapons. If we want to keep an eye on Iran and make sure they don't develop nuclear weapons to threaten their neighbors in the Middle East and the rest of the world, we need this international force to come in and do its inspection work. They are the only credible third parties that can come in and decide whether the Iranians have gone too far. Their judgment through the United Nations is one that is credible to other nations. To cut back in their efforts at monitoring the spread of nuclear weapons is, in my mind, shortsighted and invites instability in a world that is already too dangerous.

I urge my colleagues to defeat the Coburn amendment. I say to my friend from Oklahoma, at the end of the day, after we start this program, if the Veterans Administration can find the resources through the appropriations to move it forward, I am open to working with him to expand it to caregivers from previous generations of veterans and to see if there is a way to make sure it is spent exactly where it is needed and as we have described it.

That is the nature of this work. We are not perfect in what we do, but we start with good intentions and hard work and try to put the language together. But at this moment, I say to the Senator from Oklahoma, first, I am glad he no longer put a hold on this bill. It is an important bill. I am glad he has had his chance to offer his amendment. I urge my colleagues to defeat it, but I say it in good faith to my friend from Oklahoma.

I will work with him if this bill, in fact, is enacted into law and implemented to make sure it meets the goals we both share—fairness to all veterans and providing care to those who need

it. This is a good start, but let us promise to work together, if it is enacted, to make sure we continue in that vein.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, the majority whip is a formidable orator and he is appreciated in lots of ways. We work together on subcommittees on the Judiciary Committee. I have a fondness for him. Although one area he did not agree to work with me is to pay for it.

Never have I said I don't want us to do this for our veterans. Not once. The reason we are on the floor, the only reason we are on the floor having this debate is because of my hold; otherwise, we would never have gotten here to have the debate which I think is valuable for the people in this country.

But there has to come a time—every time I offer an amendment on this floor is never a good time—to start making our choices. That is what we hear all the time. Over 600 times in the last 4½ years, it is never a good time to start making hard choices. That is just what we heard.

The Senator from Illinois referenced Congo. Just this month the Congolese army, with the assistance of the United Nations, slaughtered a bunch of people. And we are supposed to continue?

I put two other things out there. Under Federal law, the Accountability and Transparency Act, the United Nations is required to tell the American people how our money is spent because the State Department is required to find it out and put it online. They have refused to do it. So we have no idea what it is.

Two years ago in the Foreign Ops bill, an amendment was agreed to by 100 Senators that there would be transparency. Our money going to the United Nations would be conditioned on the fact that the United Nations would be transparent on how it was spent. That was voted 100 to 0 in the Senate.

Guess what happened on the way to the bank coming out of the conference committee. It was eliminated. So now we send over $5 billion directly, $5.2 billion, plus billions more through USAID through the United Nations, and we do not have any idea how it is spent.

What we do know is that the United Nations is fiscally and morally bankrupt. It is loaded with fraud, loaded with duplication, and loaded with excess.

It would be a wonderful thing to send the United Nations a wonderful fire shot across the bow that they have to start being accountable for the dollars that the American taxpayer, that this little girl is sending them out of her future every year. It would be a wonderful thing for us to say that.

It is unfortunate, every time when we get down to the point where we have to make a hard choice, we always choose not to make the hard choice. That spells disaster for our country, and it also spells a total lack of leadership on our part to recognize what the real problems are that are confronting this country.

Our veterans deserve us to take care of them. I am for that. Our children deserve for us to do it in a way that protects their future—the very thing for which our veterans serve.

Unfortunately, we will not do that with this amendment or any other time until the American people decide they have had enough of the careerism, the elitism, the lack of integrity, the lack of courage that is so often represented in the votes we cast in this body.

I reserve the remainder of my time, and I yield in my absence any time the Senator from North Carolina wishes to take from my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I wish to be recognized under the 6 minutes I currently have available to me, and if the clerk will notify me at the end of that time, then I will go into Senator COBURN's allotted time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BURR. Mr. President, I wish to reiterate, as the ranking member of the Veterans' Affairs Committee, this bill was reported out unanimously. I think it will receive unanimous support in its passage later this afternoon in the Senate.

Let me restate for Members, when the committee passed this bill out, we passed it out with all caregivers being included. It was after the committee reported it out that we narrowed it to OEF and OIF veterans and their caregivers. It was the intent of the committee to include all the people Senator DURBIN, the majority whip, said we might consider later on but not now. The committee's intent was let's do it in the bill now.

It was also the committee's intent that these were individuals who were targeted for us to provide this caregiver benefit to so we can keep them out of nursing homes because of the Ted Wades, because of the Eric Edmundsons.

Senator COBURN's amendment is consistent with the bill that was passed out of committee unanimously. The bill says the Secretary ''shall;'' therefore, it means he has to. The Secretary will then have to prioritize spending within the Veterans Administration to fund these programs. The third piece of what Dr. COBURN's amendment does is rather than force the Secretary to prioritize within just VA programs, meaning there are going to be veterans who win and veterans who lose, why not say as a Congress: Why shouldn't we do what we are supposed to do? Why should we not prioritize the spending here?

What my good friend from Illinois suggested was why should we prioritize for the United Nations? Let me say the answer is quite simple: It is our money. The suggestion that the Congress doesn't have a fiduciary responsibility to fund programs we implement at a time we are borrowing 50 cents of every dollar we spend is ridiculous on its face.

To suggest that the Senate, the Congress can operate any differently than a family in America suggests that we ignore the input of everybody who asked us to represent them. We do represent the American people, 100 individuals who represent the entire country. How can we do it differently than any family who is out there struggling to meet their end-of-the-month obligations and when their revenue does not meet their expenses? What do they do? They either cut back their expenses or they find a place to raise more revenue.

Let me suggest this is as simple as, Is it time for us to prioritize where we are placing money? Members will have to decide: Is pulling money from the United Nations an appropriate place for us to pull money from to then spend on our country's veterans?

I believe we have an obligation, I believe we have a promise, even for programs that did not exist prior to this time, that when we see it is in the best benefit of the quality of life of our troops, that we provide that benefit for them. But I believe we also have an obligation to this generation and the next one and the next one to pay for it.

This is not a choice that is tough for Members. If you support the Coburn amendment, you support practically everything the committee supported when we passed the bill out by unanimous consent. If you support the Coburn amendment, you believe we have an obligation to pay for it. The only reason you would vote against the Coburn amendment is because you don't think it is appropriate for us to deprive the United Nations of this money to use as they see fit.

I suggest this is where the disconnect is with the majority of America. They would prefer the Senate to decide where that money went and to use it on these caregivers and these veterans programs.

I encourage my colleagues to support the Coburn amendment, support passage of this bill this afternoon when we take it up.

I wish to shift gears slightly because I think it is somewhat ironic that we are talking about expansion of services to our Nation's veterans at a time when some herald the introduction of a bill that, in all likelihood, will deprive other Americans of the ability to have affordable health care.

We have gone through several months of debate now about health care being accessible and affordable for all Americans. We have talked about reforms; let's change the system; let's reform the system; let's make it accessible and affordable; let's bend the cost curve down. In the last 24 hours, some have come and said we have accomplished that, it is amazing.

Let me remind my colleagues, we have all said health care is

unsustainable in its current level of investment, 17 percent of our gross domestic product. I find it somewhat odd that we would start the debate given that it is unsustainable in its current financial investment with how much more money does it cost to reform health care. The obvious answer to me is it should cost zero. If you are already spending too much, we should look at the reforms before we look at the coverage expansion.

I agree every American ought to be covered. As a matter of fact, Dr. COBURN and I have offered comprehensive bills to do that. But it is matched with real reform.

What was heralded in the last 24 hours is, in fact, a $2.5 trillion health care bill—$2.5 trillion—over a 10-year period of collecting the revenues and paying out the expenses. This is where gimmicks, smoke and mirrors—whatever you want to call it—are used in Washington. If you collect revenue for 10 years but you only pay benefits for 6 years, you don't get a true picture of what it is going to cost over 10 years. You get a true impact of the revenue stream which is over $800 billion.

From where will that $800 billion in new revenue appear? Taxes. They go up $493.6 billion—$493.6 billion. We will cut $464.6 billion out of Medicare. A $½ trillion we are going to take from a program with a designated population of beneficiaries of our Nation's seniors and those who are classified as disabled and we are going to take $½ trillion from Medicare and shift it over to meet the new burden of a health care plan yet to be constructed.

Why is this problematic? It is $1,063 per Medicare beneficiary every year. Over the 10-year cycle of this health care plan, we are going to steal from every senior in this country $10,363 worth of health care money. We are going to take it from their program, and we are going to put it over in this new program because it is paid for. Legitimately, when you raise taxes, when you raise fees, when you raise revenue, you are making tough choices. I think when you go in and tax health plans and that raises $149.1 billion; when you increase a penalty for a nonqualified health savings account and you get $1.3 billion—these are revenues. They are legitimate.

It is no smoke and mirrors. I don't think the American people believe for a minute this is deficit neutral. I don't believe for a minute they believe we are going to take $464 billion out of Medicare. If they do believe it, they know we are going to pay it back with future taxes on the American people.

That is fine, if that is the way we want to prioritize. But health care reform affects every American. This is a very personal issue for every American and every family. It touches them unlike anything else we do. The truth is, they know if you take it and you put it in one pocket and you take it out of the other pocket, the effect on them either has not changed or it is negative.

Let me suggest to my colleagues this bill is 2,074 pages. I will admit—I may be the only one—I have not read it since it was introduced at 6 o'clock last night. I am not sure there are many Members who have or could have. But let me suggest there will be a question about whether, for the first time, we use taxpayer money to perform abortions. Personally, I believe that is wrong. I will not support a piece of legislation that does that. This bill does that.

An employer mandate, at a time when American companies are trying to be competitive in a global marketplace? We raised $28 billion in employer mandates. I am not sure that is making U.S. companies more competitive in a global marketplace. I think the economy is the No. 1 challenge we have in America. I think 10.2 percent unemployment and going up—if it were a disease, we would be on the floor of the Senate calling it an epidemic and we would be doing whatever and spending whatever to help turn it around. But we are doing nothing. As a matter of fact, we are doing everything we can to try to drive up unemployment, to dry up the economy, and to make companies less competitive in a global market.

The President said one of the objectives of health care reform was we need to bend the cost curve down, we need to make sure there are cost savings in health care for every American. Let me tell you what the Congressional Budget Office says:

> Under the legislation, federal outlays for health care will increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

That is Washington language for: You know what. Our expenditures on health care are going to go up. What happens when Federal expenditures go up? Everybody's go up. That is a known fact by the American people. The coverage expansion would drive a new increase in government spending on health to the tune of $160 billion over 10 years. Make no mistake, this does not bend the curve down, it bends the curve up. We spend more money.

CBO scored the bill as reducing the deficit by $130 billion over 10 years, 2010–2019. What does it take into account, to come to that calculation? It assumes doctors are going to get cut 23 percent in their reimbursements in 2011. We have less than 1 million doctors to serve 300 million people. Does anybody believe for a minute we are going to allow a 23-percent cut to go in at a time when we are starved—trying to attract people to go into medicine as a profession? If it does go in, we are going to take $247 billion out of the pockets of doctors we rely on to perform the surgeries, to make the diagnosis for us and everybody else in this country.

The new creation of the CLASS Act, long-term care policy, shows in the CBO score a $72 billion savings. Let me explain it like this: Nobody qualifies today because it doesn't exist. People are going to pay premiums to be eligible for this long-term benefit. It takes about 20 years of paying in before somebody is going to be eligible to pull out. It is not similar to Medicare, when we created it, where, even if you never paid in, you started on day one. We are collecting revenues for 20 years before we ever pay out the first dime. It is not hard to understand why you would have a $72 billion surplus out of this.

Let me ask, what happens after that? What happens after you get past that 20-year number? The truth is, it starts to get into the trillions and trillions of dollars for which the Federal Government is obligated, based upon the premiums and the benefits people have assigned to it, that they pay out.

If you eliminated these two gimmicks, just on its face this bill would be $189 billion out of balance, in the red. It would not be paid for.

I suggest that is just two smoke-and-mirror tools. The start date was moved from 2013 to 2014. No longer is our focus on how do we get care delivered as quickly and as efficiently. We just pushed it off a year because we said the Congressional Budget Office says we are short on raising money, and we have raised all we can in fees and taxes. Maybe not all. I think they probably have some things targeted that are still yet to come out. The key thing is, even if you did implement it, there are 24 million Americans who are still without insurance. The objective to cover everybody was not met. There are $25 billion worth of unfunded mandates to our States. I don't know of a State that is in financial health today. There may be one or two.

My State of North Carolina was $4 billion out of balance. Last year, the Federal stimulus was $2 billion of closing the gap. That $2 billion, by the way, we didn't have. We borrowed to give to North Carolina and other States to create jobs. It was used to close budget gaps so they didn't have to make tough decisions. As a matter of fact, we found out this week, on one of the news channels, there is $98 billion that didn't have anything to do with stimulus.

We are the laughingstock of the world on the way we applied the stimulus package. But the sad part is not the fact that it has been uncovered, it is that it didn't do anything to put Americans to work. Now we are saying to the States we are going to put another $25 billion on you.

In Medicare, we are going to cut from the fee-for-service payments $192 billion. So we already have $247 billion over here that we are getting from doctors if we go through with the payment cuts. Now we are targeting another $192 billion out of Medicare reimbursements, right out of the pockets of doctors and hospitals. Is there a community hospital in America that will be able to survive, given the cuts that are getting ready to hit them? We cut Medicare Advantage $118 billion. Some

cheer that. I tell you who doesn't cheer it: the 20 percent of America's seniors who chose Medicare Advantage as their preferred choice to traditional Medicare because it required of them less out-of-pocket obligation, it didn't hit them for $750 deductible the day they walked into a hospital. What about those 20 percent of our Nation's seniors when they lose Medicare Advantage?

What about the $43 billion in DSH, disproportionate share payments, we pay the hospitals to make up for the uncompensated care they deliver? I guess the authors of the bill would say we are covering everybody so there is no uncompensated care. Wrong; 24 million are still without insurance. There is going to be uncompensated care, and we are taking away the money we are providing the hospitals to make up for the uncompensated care they delivered, meaning it is coming right out of their hide, that local hospital in the community we live in; $23 billion in unspecified cuts by the Medicare Advisory Board. Is America comfortable with us turning to another advisory board to cut $23 billion? We just had an advisory board say: If you are 40 to 50 and you are female, you don't need to worry about your breasts, don't need to go get a mammogram, don't need to do self-examinations—trust us.

One of the reasons the health care system in America is the best in the world is because we spend money to innovate. We hope companies find breakthroughs. We look at diagnostic abilities in an effort to try to detect early, so the options are greater and so the cost is less. But now, all of a sudden we are saying that is not important.

There are 162 million Americans who currently have employer-based health care. In this bill, regardless of what that employer does, they will not be eligible for subsidy. If they currently have coverage but they may be below income and for some reason their employer has to drop their health care or cut back on the plan because—maybe they are not competitive after this in the global marketplace—even though they would qualify from an income standpoint, they will not qualify because they were provided health care before. Our favorite, the IRS says it will take another $5 to $10 billion so they can actually go out and collect these fees and taxes.

The cost of the subsidies alone in the exchange is estimated by CBO to grow at 8 percent a year. I ask you, if the reason we have gotten into this discussion, had this debate, was we are trying to turn the cost curve down on health care, and we have quoted a 6-percent increase a year and a 5.5-percent increase a year and a 7-percent increase a year, why in the world would we be considering a plan that CBO tells us is going to have a cost increase for the subsidy of 8 percent a year? I would hope, if we had real reforms that worked, the cost of the subsidy would decline 8 percent a year.

I know there are others seeking time. I will not belabor this point. I ask Members: Support the Coburn amendment on the veterans bill. Support passage of the veterans bill. Read the health care bill. Be prepared to debate the health care bill for a very long time and be prepared to stand for the American people on what is right.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, as has been mentioned several times, the majority leader unveiled the Democrats' health care reform bill yesterday around 5 o'clock. This bill was drafted behind closed doors. There was no Republican input. It didn't have any transparency until yesterday at 5 o'clock, despite the promises we have heard that government would be more transparent in this new administration. The 2,000-page bill released yesterday is expected to have a vote to proceed to it within the next 2 days. The bill is 354,654 words. To put it in perspective, the Bill of Rights is stated in 463 words; Lincoln's Gettysburg Address contained 266 words; the Ten Commandments has 297 words. This is over 350,000 words.

Why don't we have time to read this bill, digest it, allow our amendments to be put in the bill language, because, clearly, this bill will need amendments?

The health care of our citizens may be the most personal of all things to every person and every family. We are a democracy and the American people have a right to be heard on all issues but especially on this type of issue. We should be given the opportunity to read and hear what is in this bill, to hear it discussed, to hear from our constituents because it ought to be on the Internet. That is why we have the Internet access to bills that are introduced in the Senate. But by the time our constituents have a chance to read it, we will already have had a vote on whether to proceed to the bill.

Even after a cursory review, I know this bill includes changes that are disastrous to families, health care providers, and the economy. Higher taxes, mandates—especially for small businesses—penalties, cuts to Medicare, higher premiums, restricted choices, a government plan—the list goes on. The bill includes almost $1 trillion in taxes, including a new Medicare payroll tax; $8 billion in taxes on individuals who don't buy coverage; $149 billion in taxes on employers who don't offer the right percentage of coverage to employees; $102 billion in taxes on insurance plans, pharmaceutical companies, and medical device companies which study after study have shown will be passed on to the people who get these services and equipment.

To make matters worse, the bill includes almost $1 trillion in cuts to Medicare. It is guaranteed to reduce choices and coverage for seniors. In my State of Texas, 400,000 people love their Medicare Advantage, or at least they have it and are satisfied. They will lose Medicare Advantage under this bill. The Democrats are touting the cost of the bill as meeting the President's goal of being under $1 trillion because CBO scored it at $849 billion. But this is a budgetary sleight of hand, because what is actually being scored is the years 2010 to 2019. The actual spending in this bill won't take effect until 2014. They are taking the 10 years with 4 years where the bill is not spending anything. If you score it for the 10 years following when it actually comes into being, 2014 to 2023, the bill costs $2.5 trillion, not $849 billion.

Given more time to analyze this bill, who knows what else we would discover? If the Democrats think this is the reform Americans wanted, why rush the bill through the Senate? Why rush it through before we have the ability to review details?

The right approach is available. My colleagues and I have proposed commonsense and fiscally responsible ways to improve affordable access to health care. We need to do that. We have never said we don't need reform. What we have said is we need reform that will give more affordable access for coverage to Americans who do not have that access today.

We should reassess the goals of health care reform and implement policies that we know will reduce costs. For sure, reducing frivolous lawsuits. Study after study has shown the benefits of medical malpractice reform. In Texas, we have tort reform. We have seen a dramatic increase in physicians who are willing to practice medicine. It has lowered the cost of medical malpractice premiums, and doctors have been able to do their work with their patients with much more freedom, knowing they do not need to order unnecessary tests just to cover themselves in case they get sued. The majority insists on rejecting this suggestion that we have medical malpractice reform in the bill. Yet there is probably not anything that will save as much money as medical malpractice reform, that puts commonsense standards in place for frivolous lawsuits or lawsuits at all.

I will offer an amendment, or at least prepare one and hope to be able to offer it, that would cap damages, reduce malpractice premiums, and encourage doctors to practice in medically underserved areas. So many of our underserved areas, especially rural areas, have no doctors. There are counties in Texas that don't have a doctor within hundreds of miles and several counties. That is because the medical malpractice premiums are so high, they cannot afford to do it.

The small business premiums are going to go up, if this bill is passed. Small businesses already have a hard time offering coverage to their employees. Why would we make the problem worse, especially when we have the highest unemployment in decades? We should be allowing small businesses to pool together and buy plans. We have

championed that proposal for years in the Senate, but we have never been able to get over the hurdles to pass a small business health plan. If we could do that, we could spread the risk. The bigger risk pools would produce lower premiums and allow more small businesses to have access to and offer their employees affordable health care coverage. Allowing businesses to pool doesn't cost the government anything. Therefore, it would not require tax increases, as we see in the bill before us.

The Democrats are trying to address the problem of unaffordable insurance by offering credits to small businesses to offset the cost of premiums. But the credit only lasts for 2 years. That is hardly anything that is going to encourage businesses to take on the added cost when the credit lasts for 2 years. I will be preparing amendments that at least double that to 4 years, expand the eligibility and duration of these credits so we can help small business people. But even 4 years is not enough. We should offer credits all the way through.

Offering tax incentives. There are small businesses and individuals in this country who have no access to affordable coverage. Why not give every individual who purchases their own health insurance the same tax break a corporation gets for offering health care coverage to their employees? Employees who receive insurance through their place of employment do not pay taxes on the premiums they spend for insurance. Why should individuals who purchase their own health care coverage be treated differently? I have a bill, with Senator DEMINT, that will help provide insurance for more Americans through tax credits and competition. Our approach would be a tax credit for every individual, $2,000 per year, and for families $5,000 per year for their purchase of health insurance. This would allow individuals to purchase their policies and own them so they would not have to be affected by what their employer offers or if they change jobs. This is the kind of reform that could make a difference.

How about creating a transparent marketplace online for consumers to go in and shop and hopefully have bigger risk pools, more competition, bringing the cost down? That is not the kind of marketplace that is in this bill. This exchange has so many mandates on the plans that, like the Massachusetts exchange, it would raise the cost of premiums and would not help in any way bring the cost down so that premiums are more affordable.

These are the ideas that would improve competition in the marketplace.

I can tell you, from the input I have received from my constituents since the bills have been out of committee, before the bill came to the floor or is on its way to the floor yesterday, because there were two committees that wrote bills that were put together and released yesterday, I have listened to what people say. I can tell you they don't want Medicare cuts. They don't want more taxes. Small businesses certainly don't want more mandates. They don't want government-run insurance. They know that a government plan is eventually going to crowd out the private insurance company plans throughout the country.

I am going to be preparing an amendment that will allow States to opt out without penalties, not just of the government insurance plan but of all the harmful measures. Why would we have a government opt-out by States, if they are going to still have to pay the higher taxes, if they are going to have to pay higher premiums to pay for the other States that have the plan? States should not be forced to participate in the government plan, nor subsidize and pay for such a plan through increased taxes.

I will prepare amendments that will exempt individuals and employers from the mandate to buy insurance, if this bill causes premiums to rise above their currently projected values.

The solution to health care issues is not to give more power to the government. The solution is to give more power to the American people. They deserve a system that assures that America will have the best health care in the world.

Which brings me to the new government task force that came out this week that is causing confusion at best and outrage at worst. That is the guidelines regarding screening for breast cancer. Breast cancer is the second leading cause of death in women in this country. Whether and when to screen for breast cancer has been debated for decades. In 1993, the Clinton administration proposed the government takeover of health care. In that proposal put forward by the Clinton administration, there would be no payment for mammograms for women under the age of 50. After the age of 50, there would be payment in the government plan for a mammogram every 2 years, exactly what has just been recommended by the Federal task force.

Since we have had the guidelines, which have been in place for many years, death rates from breast cancer have been declining. Since 1990, there are larger decreases seen in women younger than 50. The American Cancer Society states that these decreases are believed to be the result of early detection and increased awareness. The evidence has repeatedly shown that screening and early detection save lives.

Unbelievably, the United States Preventive Services Task Force has recommended against routine mammograms for women under 50, saying it is not worth subjecting some patients to unnecessary biopsies, radiation, and stress. The task force also recommended against teaching women to do regular self-exams. We have to ask the questions: Why this change? Why now? Nothing substantial in the clinical evidence, but the panel decided to review the data with health care spending in mind. Nearly everyone realizes that fewer screenings mean insurance plans, including a government-run plan, will save money.

This is how rationing begins. I hope America wakes up. This is how rationing begins.

In an article by the Wall Street Journal today, they recognized that. It reads:

> Every Democratic version of ObamaCare makes this Task Force an arbiter of the benefits that private insurers will be required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

That is a quote from the Wall Street Journal today.

The American Cancer Society came out after this incredible recommendation and said, with its new recommendations, the task force is essentially telling women that mammography at age 40 to 49 saves lives, just not enough of them. So if the screening is going to save your life or your mother's or your sister's or your wife's, would that screening be worth it?

Decisions about care must be between a doctor and a patient, not a doctor who has a loyalty to anyone but the patient, not a doctor who is working for the government and having to maintain government task force guidelines, such as the one we have just seen.

That is the crux of the debate on this health care bill that has been released in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching diseases such as breast cancer and colon cancer before they get worse. It turns out, there is a reason: cost.

The insurance companies have sort of said in the last day or so that they are not going to stop the coverage of mammograms for women starting at the age of 40. But when the government plan comes into effect, you know that every insurance company is going to say: If we are going to be competitive, we must adhere to the same standards as the government plan. It is going to happen.

We must have time to look at this bill. We must have time to look at what is happening to the choices, to the health care, to Medicare. The cuts in services, the taxes, the mandates are going to overhaul the health care of our country. We must have time to look at this bill before we have a motion to proceed. We must have time to study it. We must let our constituency study it because they will catch things they care about and they will inform us, and that is why we are here.

So I am very concerned that we are pushing too fast on something we should be taking slowly and carefully to assure we are not going to do something we are not sure is right, and

where we have the chance, to change what we see is wrong.

Thank you, Mr. President.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). The Senator from Arizona.

Mr. KYL. Mr. President, I wish to compliment the Senator from Texas for sounding this warning. Being from Texas, she is undoubtedly aware of a great country-western song out right now by Brad Paisley called ''Welcome to the Future.'' I think we have seen a glimpse of the future under Obamacare here by this pronouncement of the U.S. Preventive Services Task Force recommending against the routine screening of women between ages 40 and 49 for best cancer.

I want to speak for about 60 seconds about this issue to go into the actual numbers from the study to which Senator HUTCHISON referred. The rationale of the study is that you would need to screen 1,339 women in their fifties to save 1 life, so screening is worthwhile. But since you would need to screen 565 additional women—in other words, 1,904, to be precise—in their forties to save 1 life, screening is not worthwhile. That is the kind of cost-benefit analysis that will result in rationing, and it is precisely Senator HUTCHISON's point that this is how rationing begins.

Welcome to the future.

Mrs. HUTCHISON. Mr. President, if the Senator will yield, I appreciate him giving us these statistics because it is 1 life out of 1,904 to be saved, but the choice is not going to be yours; it is going to be someone else who has never met you, who does not know your family history.

That was in the Clinton government reform, takeover of health care in 1993, and it was soundly rejected. It was soundly rejected. It was part of the reason it was soundly rejected—this mammogram rationing before the age of 50—because we had hearings on this, and every woman in the Senate at the time rejected—rejected—that plan, rejected keeping women under the age of 50 from having mammograms paid for by insurance plans.

So I thank the Senator from Arizona for connecting this and showing the statistics because this is not the American way of looking at our health care coverage. It is not the American way, and we must stop this government takeover of our health care.

Mr. President, I yield the floor.

Mr. KERRY. Madam President, I speak in opposition to amendment No. 2785 to the Caregivers and Veterans Omnibus Health Services Act. This amendment, offered by Senator COBURN, would cut funding for international organizations, including U.S contributions to NATO and the United Nations. This would gravely undermine our vital national security interests at a critical time. We all strongly support strengthening medical care for our Nation's veterans, but Senator COBURN's amendment sets up a completely artificial choice between protecting the health of America's veterans and ensuring that our Nation meets its national security objectives and international obligations.

To be clear, this amendment would cut funding from the contributions to international organizations account, which provides the assessed dues to the U.N. and NATO, APEC, OAS, OECD, and the OPCW, as well as take funding from the contributions to international peacekeeping operations account. That is why I will oppose this amendment, for several critical reasons:

First, we obviously need as much support as we can get from our NATO allies for our joint mission in Afghanistan. We cannot, and should not, carry this burden alone and how can we ask NATO to do more while we are at the same time cutting our NATO contributions? This would seriously undermine our standing with NATO and with our NATO allies at a time when we can least afford it. We simply cannot allow that to happen.

Several other international organizations are also threatened by this amendment. Funding for the Organization of American States, which addresses threats to hemispheric security, from terrorism to narcotics, would be cut. The Organization for Economic Cooperation and Development, which promotes economic growth in 30 member states and more than 70 other countries, would lose funding. The Asia-Pacific Economic Cooperation, which promotes trade, security, and economic growth throughout the Asia-Pacific region, and which the United States will host in 2011, would also be cut. The Organization for the Prohibition of Chemical Weapons, which ensures worldwide implementation of the Chemical Weapons Convention, as well as the World Trade Organization, which provides the stable framework for international trade that is so critical to the United States, would suffer funding cuts.

Second, our United Nations contributions fund a wide range of U.N. activities in support of key United States foreign policy priorities. U.N. organizations are monitoring nuclear programs in North Korea and Iran. We need the best information possible about the nuclear programs in Iran and North Korea, and the last thing we need to be doing is cutting funding for the very organization that is doing on the ground monitoring. The U.N. is also providing vital assistance for the upcoming elections in Iraq, which will be critical to the future of democracy there. U.N. food and agriculture agencies are compiling forecasts of global agricultural production, identifying areas of likely famine and severe hunger, and facilitating emergency food assistance. U.N. health agencies are on the frontlines of detecting outbreaks of avian flu and H1N1 and defending against a world pandemic. In addition, we work through U.N. organizations to protect a range of U.S. interests, from the intellectual property rights of American entrepreneurs to coordinating international aviation safety standards.

Third, passage of this amendment would directly threaten ongoing peacekeeping operations in nations essential to America's national security interests. There are now over 115,000 peacekeepers the second largest deployed military in the world serving in 17 missions in some of the most dangerous corners of the world. These U.N. peacekeeping operations are working to preserve peace and stability in fragile countries with grave humanitarian situations, including Darfur, Liberia, Lebanon, Haiti, and the Democratic Republic of Congo. U.N. peacekeeping is eight times less expensive than funding a U.S. force, according to the Government Accountability Office, and these peacekeeping operations help shoulder the burden with our military. U.N. peacekeeping missions also help end brutal conflicts, support stability, the transition to democratization, and bring relief for hundreds of millions of people. And if not for U.N. peacekeeping missions, some of these conflicts could require the presence of U.S. soldiers.

Haiti is a good example. The U.N. force in Haiti has dramatically reduced the number of kidnappings that plague the nation and helped deliver food and medicine, clean streets, and maintain security after several successive tropical storms devastated the country. The mission in Haiti is in the midst of a successful transition from keeping the peace to enhancing security for the people of that country. In the 1990s, Florida faced wave after wave of illegal Haitians trying to escape from the failed state. Should this mission be abandoned? Should we abandon the people of Darfur?

Fourth, the President has stated his commitment to paying U.S. dues to international organizations in full. As Ambassador Rice has said, we must meet our obligations. As we call upon others to help reform and strengthen the U.N., the United States must do its part and pay its bills. Our dues to the United Nations and other international organizations are treaty obligations. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations. Going into arrears undermines U.S. credibility and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy.

We all want our veterans and their families to receive the best care possible—they have earned it many times over—but this amendment presents us a false choice between caring for our veterans and protecting our global interests: we must do both. It is for these reasons I oppose Senator COBURN's amendment and urge fellow Members to oppose the amendment as well.

Mrs. BOXER. Mr. President, I rise today in opposition to amendment No.

2785 to the Caregivers and Veterans Omnibus Health Services Act of 2009.

This is a deeply flawed amendment that may hurt certain veterans of the wars in Iraq and Afghanistan. And for that reason, I must vote against it.

Severely injured or disabled veterans often need someone to care for them in the home. The family members of these veterans often shoulder the burden of this care, which can take a significant financial, psychological and emotional toll. This bill would provide a family member caregiver with health care, counseling, support and a monthly stipend.

But amendment No. 2785 actually seeks to shut certain Iraq and Afghanistan veterans out of this new benefit by mandating that only those who require ''hospitalization, nursing home care, or other residential care'' are eligible.

The Wounded Warrior Project characterized the impact of the amendment as such, stating that it would ''set a much higher bar'' by requiring that the ''veteran be so helpless as to require institutional care if personal care were not available.''

This would potentially shut out veterans suffering from severe mental illness, or those learning to adapt to life at home with blindness or amputations.

The Disabled American Veterans also echoed this concern as a reason for opposing this amendment, writing that the amendment's ''new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services.''

For these reasons, I urge my colleagues to defeat this amendment, which is also opposed by the American Legion, the Iraq and Afghanistan Veterans of America and Swords to Plowshares.

It is long past time to pass the underlying bill. This legislation is too important to our veterans to sit in Congress because of the stall tactics of one lone senator.

It includes important health care improvements for women veterans including requiring the Department of Veterans Affairs to train mental health care specialists on how to better treat military sexual trauma. It also implements pilot programs to provide child care to women veterans who require medical care.

In addition, the bill includes two important provisions from bipartisan legislation that I authored with Senator BOND.

The first gives active duty servicemembers access to vet centers, which are community-based counseling centers run by the Department of Veterans Affairs where veterans can receive mental health care services.

The second provision authorizes vet centers to counsel former servicemembers on their rights to present their medical records for review to ensure that the discharge process they underwent was fair. This is particularly important for servicemembers who may have been discharged improperly with a personality disorder and therefore are not entitled to benefits when in fact they suffer from a combat-related condition such as post-traumatic stress disorder.

We owe our veterans an enormous debt of gratitude, and the best possible treatment and care for injuries sustained in service to our country. This bill is an important step toward fulfilling that obligation.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, can you tell me how much time I have remaining?

The PRESIDING OFFICER. Remaining on the Senator's side is 31 minutes 33 seconds; on the other side, 42 minutes 15 seconds.

Mr. AKAKA. Mr. President, let me make further comments about the pending bill on the floor and speak particularly about the cost of war.

To those who are concerned about the cost of this legislation, let me say I firmly believe we cannot renege on the obligation to care for those who honorably serve our country. When we as a nation vote to send American troops to war, we are promising to care for them when they return. The cost of veterans health care is a true cost of war and must be treated as such. The cost associated with the underlying bill does not need to be offset. The price has already been paid many times over by the service of the brave men and women who wore our Nation's uniform.

Regardless of what my colleagues may think about the United Nations and its role in international affairs, this is not the time or place to be debating those issues. At this moment, we are talking about meeting veterans' needs.

Iraq and Afghanistan Veterans of America agrees. IAVA writes that:

> The amendment to S. 1963 brought to the floor is just the latest in a long series of delaying tactics that plays political games with veterans' health care and services.

This bill would provide family caregivers—who typically have full-time jobs—with health care, counseling, support, and a living stipend. This modest stipend would be equal to what a home health agency would pay an employee to provide similar services.

To assert that this legislation requires excessive spending is simply wrong. This spending is critical when taking into account the sacrifices these men and women have made for the Nation.

The sponsor of the amendment we are considering has expressed the view that S. 1963 unfairly discriminates against veterans because its caregiver assistance provisions focus on OEF and OIF veterans. While it is correct that the caregiver provisions target the veterans of the current conflicts, I do not believe that constitutes discrimination. The reasons for this targeting, at the least, are three: one, the needs and circumstances of the newest veterans in terms of the injuries are different—different—from those of veterans from earlier eras; two, the family situation of the younger veterans is different from that of older veterans; and three, by targeting this initiative on a specific group of veterans, the likelihood of a successful undertaking is enhanced.

I note that most major veterans groups support this bill and the caregiver provisions. I do not believe they would do so if they felt it was discriminatory.

As my colleagues know, I am a veteran of World War II. If we can provide help to the newest veterans in ways that were not available to the veterans of my generation, I support that 100 percent.

Veterans from Iraq and Afghanistan are returning home today to face new and different challenges. In World War II, a third of those injured on the battlefield did not make it home. Today, 90 percent of those injured make it home but often with catastrophic and life-threatening injuries. Some of these injuries leave invisible wounds. Unprecedented rates of post-traumatic stress disorder and other mental illnesses are affecting these young men and women. These veterans will be cared for somewhere, and by what we do today, we may decide whether that care occurs in a nursing home or in their own home. The soldiers of my generation had no such choice. I say, let's help the Nation's newest veterans to really come home, and let's help their families.

According to a report from the Center for Naval Analyses, 84 percent of caregivers for veterans were either working or in school prior to becoming a caregiver. An employed caregiver will lose, on average, more than $600,000 in wages, pension, and Social Security benefits over a ''career'' of caregiving. The younger the veteran's family, the more wages a caregiver will lose. We can no longer ask our newest generation to bear the cost of the Nation's obligation to care for its wounded warriors.

The premise of the amendment seems to be, if it is good for some, it is good for all. But the needs of veterans are not the same, and expanding a benefit to any veteran who might benefit could endanger the entire program. The underlying bill already includes a provision directing VA to report to Congress within 2 years after the law's enactment on the feasibility of expanding the provision of caregiver assistance to family members of veterans of prior service. Such an approach is not discriminatory; it is the responsible way to approach the issue.

I note that other health care improvements which would result from this bill help virtually every group of veterans, including women veterans, homeless veterans, and veterans who live in rural areas.

I urge this body to reject the amendment and pass S. 1963 today for the sake of all our Nation's veterans.

Questions have been raised about the scope of the caregiver provision. When the bill came out of the Veterans' Affairs Committee, it included a 2-year delay before the caregiver benefit could have been expanded. The bill as reported said the Secretary of VA could have expanded it to all veterans if it made sense. Under the bill now before us, the Congress will continue to have the opportunity to expand it beyond OEF and OIF veterans. Nothing has changed. Once VA has experience with the proposed new program, it can be expanded to all veterans.

Mr. President, I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, 25 years ago—I will never forget this—I came home to my house, I was 15 years old, I was in high school, and my mom and my dad sat me down and my mom told me that she had breast cancer. After that, as any kid would, I worried about whether my mom was going to live and what life would be like without a mother. It was a very difficult time for our family.

The good news is that my mom, through self-examination, found a lump, and she is today, 25 years later, a breast cancer survivor. But I am not sure I could tell this story today and tell about the positive result that occurred if she had not undertaken that self-exam, if she had not received the care she was given so quickly and so effectively because she found the lump after having been trained and encouraged to do self-exams.

So she is a success story, and millions of women across this country are success stories because they have heeded the advice of preventive medicine. They have heeded the advice for many years now from the American Cancer Society and other experts that self-exams and mammograms for women in their forties prevent breast cancer, and they prevent us from losing our moms and our sisters and our daughters. But this week, a task force, a government task force, kind of ironically named the ''U.S. Preventive Services Task Force,'' contradicted their previous recommendations and said women in their forties shouldn't be doing self-exams; that women in their forties shouldn't be having mammograms on a regular basis. That makes absolutely no sense.

We are in a world where everyone agrees the way to reduce health care costs and to increase longevity of our people is through preventive medicine. We know through the success we have had in recent years that self-exams and mammograms save women's lives.

There are going to be what they call false positives, women who find something that turns out not to be a lump. And, sure, they are going to be anxious during that time period while it gets checked out. But would you rather have your mom, your sister, your daughter be anxious for a couple days and get a good result or would you rather have them, on the other hand, not do the self-exam, not get the mammogram, and get cancer and potentially die? It makes no sense.

We know these mammograms for women in their forties save lives. We know self-exams save lives. It is not just me saying it; the facts show it. The American Cancer Society notes that deaths for breast cancer since 1990 declined by 2.3 percent, and they have declined 3.3 percent for women in their forties and fifties. Lives are being saved.

So why would this government task force that is supposedly focused on prevention want to do away with self-exams and mammograms on a regular basis for women in their forties? What could be the reason?

The reason, as my colleague from Texas so eloquently stated, is cost. It doesn't make sense anymore because we are not saving enough lives for the money that it is costing for mammograms. Our moms and our daughters and our sisters are worth that cost.

If you want to get a picture of where we are going with this new health care proposal and you want to know what the future is for how the government and your insurance company are going to view your health care, just take a look at this recommendation. Are they next going to say the same thing about men getting prostate exams in their forties? Are we going to start making these cost-based decisions or really furthering them to a degree that we haven't seen before? Are we going to lose our family members because we are rationing health care? These are big issues.

The American people, as my colleague from Texas said, need to wake up and they need to watch what is going to happen in this Senate, this great body that debates the important issues. Never has there been an issue as important in modern times as what is going to happen over the next month or 6 or 8 weeks as we discuss these issues that are going to affect our health and our families' well-being.

I sent a letter to Secretary Sebelius yesterday on this issue. I saw her comments yesterday where she disagrees with this panel. I commend her for that. Women do not need to get the message now that they shouldn't be doing self-exams. Women should not be getting the message that they shouldn't be getting regular mammograms in their forties. They need to do both things because it is going to help save their lives. No government task force, based on lack of any new information, should contradict its prior recommendations that they do just that.

I had a chance to speak with the surgeon general of the State of Florida, Dr. Ana Viamonte-Ros, yesterday about this issue, and she concurs with me, as does the American Cancer Society and other groups, including the American College of Obstetricians and Gynecologists, that women should still do self-exams, and they should still get mammograms on a regular basis in their forties.

I wish to read for this Chamber a letter—an e-mail, actually—I received today from a friend of mine down in Broward County from my home State of Florida. She writes:

> Please thank the Senator for his efforts on this important issue. I am a breast cancer survivor who was first diagnosed before 50 years of age having a mammogram. Subsequent to the mammogram, my tumor was removed surgically. Unfortunately, within 5 years, I was diagnosed again with breast cancer in the other breast and had to undergo surgery and chemotherapy. The second time I found the tumor through self diagnosis. Every day I thank God that I had a life-saving mammogram and that my doctor showed me how to do a self examination.
>
> Just recently I learned through TV that there are also recommendations that women should not utilize self exam as a way to detect breast cancer. It's too unreliable. More hogwash. Most of my breast cancer sisters found their tumors through self exam. Please ask the Senator to dispel any efforts or notions that self exam is not a good means of detection.

This is an important issue. We need to get the message out to the women of America that these recommendations are wrong. I only can stand here today with this good story about my mom because if she wouldn't have done that self-exam, she might not be here with us.

So I hope the American people will, as my colleague from Texas said, wake up and see what this means and what this portends for the future.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make further comments on some of the concerns our speakers have had.

The sponsor of the amendment has stated his primary goal is to increase veteran eligibility for caregiver assistance. It appears, however, that the amendment could well have the opposite effect and deny caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance.

The amendment would add a provision that would require that in addition to sustaining a serious injury and requiring personal care, a veteran would have to be so helpless as to require institutional care if personal care services were not available. This proposed modification is problematic because not all veterans in need of caregiver assistance would be appropriate for, or in need of, institutional care.

To illustrate, consider the example suggested by the Wounded Warrior Project, one of the principal advocates for the caregiver legislation: A veteran who is recovering from severe wounds, suffers from PTSD and depression, and needs help with feeding, dressing, and getting to the bathroom, under the provisions in S. 1963 this veteran would

be eligible for caregiver assistance. However, since the veteran in this example would not necessarily benefit from or require institutional or residential care, the veteran would not be eligible for caregiver assistance under the changes proposed by the amendment. Given the veteran's co-occurring PTSD and depression, however, the VA's failure to provide that assistance could have a severe impact on the veteran's mental health and well-being. PTSD, one of the signature wounds of the current war, is a condition which many long-term institutional care settings and nursing homes are not prepared to handle or treat. As a result, the inclusion of this new eligibility condition would exclude many veterans in critical need of caregiver assistance.

There is another problem raised by the amendment's proposed expansion of the caregiver assistance to all veterans. By expanding eligibility for caregiver assistance to all severely injured veterans, the amendment would convert a manageable initiative targeted on the veterans of the current conflicts into a huge undertaking that would surely encounter many problems.

The reasoning behind initially administering services to a smaller pool allows for greater efficiency and the opportunity to improve before expanding such services to a larger universe of veterans.

I note that the Disabled American Veterans argues against the pending amendment because of its potential impact. DAV writes, and I quote:

While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support the Coburn amendment to S. 1963.

I ask unanimous consent that this letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DISABLED AMERICAN VETERANS,
November 19, 2009.

Hon. DANIEL K. AKAKA,
Chairman, Senate Veterans' Affairs Committee, Russell Senate Building, Washington, DC.

DEAR CHAIRMAN AKAKA: On behalf of the Disabled American Veterans (DAV), thank you for introducing and quickly bringing to the floor S. 1963, ''The Caregiver and Veterans Omnibus Health Services Act of 2009.'' DAV strongly supports Senate approval of this legislation as introduced, and urges all Senators to support its passage.

S. 1963 combines the content of two prior measures (S. 252 and S. 801) into a single VA health care omnibus bill that would make significant enhancements in VA health care services. This legislation contains vital provisions to help assure equal access to and quality of medical care for women veterans. S. 1963 would also provide desperately needed support to family caregivers of severely disabled veterans, particularly those returning from Iraq and Afghanistan, as well as expand mental health services, improve traumatic brain injury care and aid homeless veterans.

As we have shared with you in testimony earlier this year, DAV believes that disabled veterans of all eras could benefit from family caregiver support services. While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support this Coburn amendment to S. 1963.

Mr. Chairman, we look forward to continuing to work with you, Ranking Member Burr, your counterparts in the House and others to craft and enact the most expansive and effective caregiver assistance program that we can achieve. Again, thank you for your vigorous leadership on this legislation and for all you have done to support disabled veterans and their loved ones who care for them.

Sincerely,

JOSEPH A. VIOLANTE,
National Legislative Director.

Mr. AKAKA. Mr. President, the proponent of this amendment has expressed the view that this veterans omnibus bill should be paid for and seeks to do so by directing a transfer from the State Department to VA of funds appropriated for ''Contributions to International Organizations'' and ''Contributions for International Peacekeeping Activities,'' both of which are categories of huge U.S. payments to the United Nations.

Regardless of any Senator's beliefs about the role of the United Nations or U.S. support for the U.N., this is neither the time nor place to be debating those issues. For that reason alone, I believe the amendment should be rejected.

I understand from CBO, however, this amendment does not even accomplish what I believe the amendment's author intends. According to CBO, the cost of the bill would still be estimated at the same level. According to CBO, having the State Department transfer funds to the VA is no different than having VA fund it through its own appropriations accounts.

It also appears that the amendment would change nothing with respect to U.S. payments to the U.N. Again, according to CBO, if the amendment's author wishes to have the State Department transfer funds to VA instead of contributing to the U.N., the amendment would have to be made to the State, Foreign Operations, and Related Programs Appropriations Act, and not to the pending measure which is an authorization bill.

This legislation has been delayed too long. To continue to obstruct this vital veterans bill while attempting to link it completely to unrelated U.N. spending is simply unacceptable.

This amendment should be rejected and S. 1963 should be passed by the Senate.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I listened very carefully to the chairman of the Veterans' Committee. He misses one major point: If, in fact, we don't send the money to the U.N., we will have money to pay for the veterans—if we don't send the money.

That is what this amendment does. It precludes that money from going from the State Department's budget to the U.N. I admit it is fungible, but that is money we will not send to something that is low priority, that is wasteful, that is nontransparent, and that the vast majority of Americans agree we get very little value from when we send that money to the U.N.

I also take issue with my friend's words that it is time. I think the chairman will agree that this bill was not noticed until October 28. That is when this bill was noticed. When the bill was noticed, the next day a unanimous consent request came through to say pass this without any debate, without any discussion, pass it through the Senate. I said, no, we ought to have a debate. At that time, we offered the Veterans' Committee a list of some 20 options of things that are lower priority than helping our veterans. They were rejected out of hand, which is the problem I have been describing on the floor earlier.

Every time it comes down to making a choice, the majority of this body chooses not to make a choice, not to choose a priority, not to do what we get paid to do, not to do what is in the best interests of the Nation. They choose to not choose. But by choosing not to choose priorities, we still choose, because what we choose is to take the money from our children. We choose to lower the standard of living of our children.

I want to tell you about veterans with whom I have spoken. I have had a lot of calls on this, because how dare somebody hold up a veterans bill before Veterans Day. The vast majority of the calls say we think you ought to support veterans, but we also think you ought to pay for it. Our country can't keep doing what we are going to do. So on the last appropriations bill through this body, I gave you an opportunity. We have heard three Senators today say there is no price we should not give to support our veterans. Direct quotes. ''No price is too great''? There is one price that is too great, because all three of those Senators who spoke those words refused to give up their earmarks to pay for veterans in the VA-MILCON bill. They all voted against paying for it in the MILCON bill by eliminating the unrequested items they had earmarked for them in the VA-MILCON bill. So, yes, there is a price that is too great—the price of helping yourself and your own constituency on a parochial basis and putting that ahead of the best interests for our veterans. So the words ''there is not a price too great'' ring hollow. We put our parochialism ahead of it.

I ask unanimous consent to add Senators INHOFE and BURR as cosponsors of my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, as we talk about this debate, as my colleagues know me very well, the debate isn't about veterans; it is not about the veterans bill. It is about reestablishing some fiscal sanity in Washington of which we have none. This bill here—the health care bill that was released last night—over the next 10 years will spend $2.5 trillion. That is what it will spend. We don't know the accuracy of CBO. They certainly haven't done very well in the past on health care, as to whether it saves money. What we do know is that it doesn't cut the cost of health care, which is the problem. It transfers $2.5 trillion under the guise of the control of the Federal Government, which is not efficient.

I have not heard one colleague defend the United Nations. Nobody will get up in this body and defend the atrocities, the waste, and the fraud of the U.N. Nobody will say that. But those same people who actually agree with it but won't do anything about it will vote against this amendment. They will vote against the amendment. They won't defend what has very accurately been described as the behavior, the lack of fiscal sanity, the fraud and theft, the rape and pillage by the peacekeepers, the lack of oversight, and the total lack of transparency. They won't defend that with their words, but they will defend it with their vote. They are going to absolutely defend it with their vote. Once again, they are going to refuse to make the hard choice. Most of them listening to this agree, but it is the wink and nod that we play around this body. They know the U.N. is a big mess. They know it is a big problem. But they won't do anything to fix it. They will vote for complete transparency and vote to condition our funds on transparency, and when they get to conference, they will take it out. They will look good on the outside, but the inside of the cup will be absolutely filthy.

When is it we will see a turnaround in Washington that will match the courage of our veterans and meet the expectation of the citizens of this country? When is that going to happen? I will tell you when it is going to happen: It is going to happen when the Chinese start selling our bonds or quit buying them. That is when it will happen. Then we are not going to be able to make those decisions based on our choice. They are going to be dictated to us. They are going to be rammed down our throats.

The fact is that $3.7 billion is a lot of money. It is $3,700 million. That is hard to think about when you start talking about billions. Yet we are going to pass it. By the way, this bill that is so critical to get passed right now has no money in it for veterans for this process. Would the chairman agree with that? There is no money there now? It is not going to happen until a year from now, unless we put it in some supplemental program between now and next September 30. So what we are promising isn't going to come due, because we turned down an amendment on the VA-MILCON bill that would have allowed money to be available as soon as the VA-MILCON bill passed the conference committee and the President signs it.

How hollow does that sound? We claim one thing but our actions are totally different. And the VA says, by the way—at least intimated—once they get this bill and the money, it will take at least 180 days to implement it. So add 18 months to right now to when our first veterans will see the benefit, especially the caregivers. And we could have, with the VA-MILCON amendment I offered—which was rejected—made that happen next month—at least the planning in the first 6 months of that—so that by March or April caregivers could actually start receiving this money.

I have tremendous worry for our Nation. If you open your eyes, you will too, because we cannot keep doing what we are doing.

Just some statistics. These are accurate, based on GAO, OMB, and Congressional Budget Office:

Ending September 30, not counting the supplemental, the Federal Government spent $33,880 for every household in this country. But we only collected an average of $18,000 per family. We borrowed, per family, $15,603 last year. Those numbers are going to be bigger next year. We are going to spend more, we are going to borrow more, and we are going to collect less. What is the implication of that? What is the implication of borrowing money we don't have and spending it on things that are not a priority, such as caring for veterans? The implication is that it will come to an abrupt halt in a very damaging and painful way—maybe not for us in this body but certainly for my children and my grandchildren, and certainly for those who follow us.

There is a bigger worry than the financial aspect of it. It is that we are losing, as we do this, the very integral part of what makes our Nation great. It is called ''sacrifice.'' That is why we honor our veterans. It is because they sacrifice, they put themselves on the line. Our heritage has been, from the founding of this country, to the very people who risk their lives and fortunes to initiate this country—the heritage has been of one generation sacrificing so the next generation can have greater opportunity and greater freedom and greater liberty.

As I said earlier, when we come back and get down to the actual voting on this amendment, most people will say: We can't do that. It is not time to make a hard choice.

I want to tell you, those veterans who have closed-head trauma made a hard choice. Those veterans who lost their lives and family made a hard choice. Those veterans who have severe disability and their families made a hard choice.

In a little while, we are going to dishonor that, because we are going to refuse to make a hard choice and rationalize in a way that it isn't going to do any good or make any difference, and we are not going to even attempt to get the out-of-control spending in Washington under control. We will reject the notion that you can, in fact, look at something and see what it is like, such as the corruption, such as the waste, such as the rape and pillaging of the U.N. peacekeeping troops, and we are going to say that is not important, and what is important is that we keep doing it the way we have always done it. We will continue to do it the way we have always done it.

The way we have always done it for the past 20 years does not honor what built this country. It doesn't honor making that sacrifice. It does not honor saying I will make a tough vote, even though the administration doesn't want me to make this vote. I will make a vote that is right for the country, right for the future, right for our kids and our grandkids. I will make that vote.

We will not see that today. We will not see the courage mustered up to choose between veterans and a sloppy, ill-run organization into which this country pours billions of dollars every year and continues unabated and uncontrolled and without oversight because we refuse to make a choice.

So my colleagues get a choice. Here is the choice: Ignore with a blind eye the absolute tragedies that are going on at the United Nations, the absolute waste, the incompetency, the favoritism, the theft that is going on and say you did something good for veterans.

The fact is, the reason our veterans have such severe injuries is because they protect our liberty, protect our freedom, and protect our future. We are not going to choose that today. We are going to choose the opposite. We are going to do the status quo. We are going to say this amendment does not make sense.

When will we muster the courage to make a real choice, to go out and defend that veterans are worth more than the waste at the United Nations? We will not make the choice because we know we can vote against this amendment and still tell the veterans we did it and we don't have to speak to our grandchildren and children. We will be gone. We will be out of here.

When their standard of living is 35 percent below the standard of living we experience today—by the way, that is what is forecast as the government takes over 40 percent of the GDP of this country and as we end up with interest costs in excess of $1 trillion a year just to fund the excesses of what we are doing today, which is less than 5 years away, and we will be spending $1 trillion a year on interest—we will have no recollection of this vote. We will have no recriminations against us. We will have just voted and said that is

another amendment to try to make us make a choice, but we refuse to make one.

By voting against this amendment, you are defending the audacity, corruptness, inefficiency, and fraudulent behavior of the United Nations. That is what you are doing. Nothing can be cut. Have you noticed that? Nothing is not important to the politicians of this city. Everybody has an interest group. Oh, we can't go against that. That is an absolute formula for disaster for our country.

I wish to enter into the RECORD some additional information on the United Nations. I only touched the surface on the amount of outlandish things that have gone on in the United Nations. I did not mention Oil for Food, billions of dollars, and of the people who took all that money, none of them got prosecuted. The U.N. Headquarters renovation is going to cost $2 billion. It should cost about $800 million. I did not talk about that or the lack of transparency in terms of the State Department, in terms of reporting how our money is spent at the United Nations.

I ask unanimous consent to have printed in the RECORD this information.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AMENDMENT 2785

REDIRECT U.S. DUES TO THE UNITED NATIONS TO THE VETERANS CAREGIVER PROGRAM

The United States taxpayer is the single largest contributor to the United Nations providing over $4 billion annually to the entire United Nations system that is estimated to be at least $20 billion. No one knows for sure how big the U.N. really is—not even the U.N. itself since it operates in an opaque, unaccountable fashion, refusing even the most basic of transparency requests.

The U.S. federal budget that is rife with waste, fraud, and abuse, but the U.N. budget is far worse. Its funding is complicated by diplomatic immunities, spends across international borders, is impossible to audit, and spent by U.N. agencies that levy taxes and fees on each other.

This amendment to the Veterans' Caregivers Bill reduces the contributions that the United States makes to the United Nations by a sufficient amount to provide caregiver benefits to ALL severely disabled wartime veterans, not just veterans injured after September 11, 2001. The current bill discriminates against veterans injured prior to that as it does not offer the same care it would provide to individuals after that date.

The national debt just passed $12 trillion and the Congress must pass a debt limit increase. Passing the veterans caregivers bill without having the increased spending offset elsewhere is completely irresponsible and further condemning our grandchildren to a lower standard of living.

UN tainted with fraud, waste, and abuse

According to internal U.N. reports, U.N. procurement programs suffer from serious fraud and mismanagement problems that taint almost half of the contracts that were audited. The report from the U.N. procurement task force found that 43% of UN procurement investigated is tainted by fraud. Out of $1.4 billion in contracts internally investigated, $630 million were tainted by ''significant fraud and corruption schemes.''

The U.N. Environment Program spends over $1 billion annually on global warming initiatives but there is almost no auditing or oversight being conducted. The U.N. Environment program has one auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified in UNEP's work.

The United Nations Human Settlements program, knows as UN-Habitat, only has one auditor, and it would take him 11 years to cover the high-risk areas alone. In cases where the U.N. auditors and investigators found evidence of administrative malpractice, the U.N. management has taken little if any action. For example, the managers of the U.N. Department of Economic and Social Affairs abused a $2.6 million trust fund given by the government of Greece. The U.N. auditors recommended that the program repay Greece, but so far, the U.N. has ignored this recommendation.

The U.N. spends $85 million annually for its Public Affairs Office, the sole purpose of which is to promote a positive image of the international body. Further, the $1 billion U.N. Foundation is devoted, in part, to pro-U.N. advocacy efforts all over the world.

United Nations peacekeeping operations

U.N. peacekeeping operations plagued by rape and sexual exploitation of refugees—In 1994, a draft U.N. report was leaked detailing how peacekeepers in Morocco, Pakistan, Uruguay, Tunis, South Africa and Nepal were involved in 68 cases of rape, prostitution and pedophilia. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, it was reported that peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted.

Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beaten to death with clubs, or shot as they tried to flee.

The UN peacekeeping mission provides substantial operational and logistics support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanda, Congolese army soldiers decapitated four young men, cut off their arms, and then threw their heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12–year-old girl, later killing four of them.

The U.S. now pays 27% of all UN peacekeeping operations. Reducing our contribution to these wasteful efforts could help ensure that UN peacekeepers are not funding widespread rape and exploitation of refugees.

U.N. wastes millions in funds for critical Afghan presidential election

The United Nations cannot account for tens of millions of dollars provided to the troubled Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of millions in U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. ''Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.'' Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired last month after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 million supporting the electoral commission with $56.7 million coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for the election.

In one instance, the United Nations Development Program paid $6.8 million for transportation costs in areas where no U.N. officials were present. Overall the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

Oil for Food

In 1996, the United Nations (UN) Security Council and Iraq began the Oil for Food program to address Iraq's humanitarian situation after sanctions were imposed in 1990. More than $67 billion in oil revenue was obtained through the program, with $31 billion in humanitarian assistance delivered to Iraq.

The Oil for Food program had weaknesses in the four key internal control standards—risk assessment, control activities, information and communication, and monitoring—that facilitated Iraq's ability to obtain illicit revenues ranging from $7.4 billion to $12.8 billion. In particular, the UN did not provide for timely assessments to address the risks posed by Iraq's control over contracting and the program's expansion from emergency assistance to other areas.

According to GAO, the Oil for Food program was flawed from the outset because it did not have sufficient controls to prevent the former Iraqi regime from manipulating the program.

GAO identified over 700 findings in these reports. Most reports focused on U.N. activities in northern Iraq, the operations of the U.N. Compensation Commission, and the implementation of U.N. inspection contracts. In the north, OIOS audits found problems with coordination, planning, procurement, asset management, and cash management. For example, U.N. agencies had purchased diesel generators in an area where diesel fuel was not readily available and constructed a health facility subject to frequent flooding. An audit of U.N.-Habitat found $1.6 million in excess construction material on hand after most projects were complete. OIOS audits of the U.N. Compensation Commission found poor internal controls and recommended downward adjustments totaling more than $500 million.

UN headquarters renovation

In 2008, the United Nations began construction associated with its Capital Master Plan (CMP) to renovate its headquarters complex in New York City. As the UN's host country and largest contributor, the United States taxpayer has a vested interest in the way funds are spent in renovating these buildings.

The United Nations headquarters renovation, now estimated to cost $2 billion from its original $1.2 billion price tag, was found to be almost $100 million over its budget before breaking ground on the project. Part of

the cost increase is due to previously hidden ''scope options'' for ''environment friendly'' options like planting grass on the roof and electricity-producing wind turbines.

First, the U.N. failed to adequately maintain its complex after 50 years of deterioration and decay. The U.N. paid millions of dollars to an Italian design firm that had to be fired under intimations of corruption after never producing a single workable plan for the renovation project.

The UN renovation project is just another example of UN spending out of control. The UN's purported $2 billion renovation budget includes over $550 million for expected increased costs and other ''contingencies.''

U.S. Taxpayers are responsible for at least $485 million in the renovation of the U.N. buildings. However, this figure is likely to rise as GAO has assessed that there exists a high risk that the project will cost much more than anticipated.

Unfortunately, the U.N. renovation program is carried out by the same system responsible for the Oil-for-Food scandal. The U.N.'s own internal audits suggest that the entire procurement system is plagued by corruption.

The current cost of the UN renovation is as follows: $890 million for construction, $350 million budgeted future escalation in costs, $200 million ''contingencies,'' $75 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million ''sustainability'' (wind turbines, grass on roof, etc).

UN European ''palace'' renovation

In addition to housing a massive bureaucracy in New York, the United Nations also keeps a European headquarters, in scenic Geneva, Switzerland. The similarity is striking, as this 70 year old building that used to house the League of Nations is reportedly in need of a billion dollars to fully renovate the ''Palais de Nations,'' as the U.N. building is known, because the building suffers from 70 year old wiring, fire hazards, rusty pipes, asbestos, and a roof caving in.

For cost comparison, $1 billion could build 407,244 square meters of office space in Geneva. That's one and a half times the size of the Empire State Building, and five times the size of the main building at the Palais des Nations.

Keeping the Palais des Nations could cost more than double what it would take to build a new home from scratch.

That $1 billion, relief groups said, is also larger than the entire humanitarian action appeal for all countries served by UNICEF, the United Nations Children's Fund, which requested $850 million to address 39 humanitarian emergencies around the world in 2008.

$1 billion could also go a long way to feed the hungry. Oxfam America reports on its Web site that ''$1,000 brings potable water to 22 families in the Rift Valley of Ethiopia,'' and that ''$20 buys enough maize to feed a family of four'' there for six months—enough food and water to feed millions and flood the valley.

The Director General in Geneva renovated his office this year, though the U.N. would not say how much the changes cost and did not specify whether a member state paid for the work. A spokeswoman said that his office was often overheated by the sun, and he had an air conditioner installed to cool it.

As the United States is responsible for 22% of the U.N.'s budget, it is entirely reasonable to expect that the U.S. taxpayer would be responsible for at least $220 million in the renovations of the U.N.'s Geneva offices.

Any major work on the Palais de Nations would likely come after the $1.9 billion renovation of the U.N.'s New York headquarters is complete, which is at least 4 years away barring further delays. The director general's figure of one billion dollars isn't on the U.N. budget yet and is an estimate that would have to be evaluated by a team of architects.

Largest money grab in U.N. history while ignoring reforms

Despite these and the dozens of other examples of U.N. mismanagement and fraud and exhortation by the U.N.'s largest donor, the United States, the U.N. refuses to stop wasting U.S. taxpayer dollars. Instead, the U.N. is receiving even increasing amounts of new funding from the U.S. and other donors.

According to the State Department, the U.N. 2008/2009 biennial budget represents the largest increase for a funding request in the U.N.'s history.

The 2008/2009 UN budget is in excess of $5.2 billion. This represents a 25% jump from the 2006/2007 budget that was only $4.17 billion and a 193% increase from the 1998/1999 budget.

The overwhelming majority of the U.N. budget goes to staff salaries and common staff costs including travel to resorts to discuss global warming—rather than direct humanitarian assistance or conflict prevention.

The U.N. has never identified offsets in existing funding in order to pay for new U.N. spending, a position that is supported by a U.N. General Assembly resolution.

Following the U.N. Secretariat's poor example, the ¾ of the U.N. not covered by the U.N. budget have experienced massive budget growth due to a complete inability to control spending. Peacekeeping is growing by 40%, the U.N. tribunals by 15% and numerous other Funds and Programs are no better off.

The State Department is willfully ignoring the law in reporting transparency on U.S. contributions to the United Nations

The U.S. taxpayer should not give billions in funding to the United Nations and then be refused basic information about that contribution. The Office of Management and Budget and the State Department are willfully ignoring the law regarding congressional reporting requirements for U.N. contributions.

In the National Defense Authorization Act of 2007 and the National Defense Authorization Act of 2010, the Director of the Office of Management and Budget (OMB) is now required by law to report annually to Congress the total cash and in-kind contributions to the U.N. from the United States. OMB has passed this responsibility to the State Department, and unfortunately, our lead agency on U.N. matters ignored this law in 2007, and when it finally provided the required funding reports in 2008, it appears that the reports are missing over $1 billion worth of funding information. The State Department has not submitted its report for 2008.

Ranking Member Ileana Ros-Lehtinen of House Foreign Affairs Committee comments on the U.N. lobbying for more contributions from the U.S.

''Last year, American taxpayers ponied up nearly $5 billion for the UN system. The U.S. is by far the world's largest donor to the UN. The U.S. provides other assistance for peacekeeping operations. The U.S. responds to emergency appeals. We are always on deck.

''Yet, the head of the UN comes to Congress and scolds us for not doing enough? He demands yet more money from us while making little progress in cleaning up the badly-broken UN?

''The UN's ineffectiveness is not from a lack of cash, but the result of a corrupt system which wastes money and apologizes for dictatorships.

''The UN has been hijacked by a rogues' gallery that uses our funds to undermine peace and security. Dictatorships use the Human Rights Council and Durban 2 conference process to restrict universal freedoms and protect extremists. The UN Relief and Works Agency (UNRWA) aid violent Islamists and partners with money-laundering banks under U.S. sanctions or under U.S. investigation for financing Islamist militants. The UN Development Program (UNDP) pays the legal fees of its corrupt officials but refuses to protect whistleblowers.

''While Iran, Syria, and North Korea endanger the entire world, the UN is preoccupied with condemning democratic states like the U.S. and Israel.

''The American people are facing serious economic challenges here at home. How can a morally bankrupt UN ask our taxpayers to bail them out?''

Mr. COBURN. Mr. President, I will finish and give the chairman the last word. What the chairman and his committee are attempting to do is honorable. It is the right thing to do to help our veterans and to secure and help those who are helping our veterans. I agree. However, I don't agree that we ought to do that on the backs of our children. I think we ought to do it on our backs. We ought to carry that load. Our children and our grandchildren should not have to carry that load. We ought to be forced to make the sacrifices to pay for the sacrifices they have made for us. This bill does not do that.

This bill takes the easy route. It says you do not have to pay for it, it is not required. There is not anything we can get rid of, after I offered all these options to the committee in terms of what they could get rid of that would pay for it.

If we don't pay for it from what I offered, then get rid of our own earmarks, the things that make us look good. We chose to keep our earmarks and charge it to our grandkids. It is a wonderful choice and a wonderful thing for the American people to see.

On this vote, they are going to see three things. They are going to see all the people who voted to keep their earmarks vote against this amendment. The first thing they are going to say is: My earmarks are more important than paying for veterans, caregivers, and everything else expanded in this bill.

The second thing they are going to see is that we do not have the courage to take on fraud, waste and abuse and lack of transparency at the United Nations. They are going to see us fail to live up to the expectations they have for us.

Everybody in America knows we are in trouble financially. They know the Federal Government is too big. They know the Federal Government is inefficient. They know we can do better. They are just wondering when we are going to start. When will it start? When will be the first time we make a hard choice? I regret it is not going to be on this bill because it is symbolic. If there ever was a bill on which we should start to make the hard choices, it should be on a bill that honors and takes care of the people who have made hard choices for us, the people who have sacrificed their lives and their future and their families for us.

The third thing, regrettably, that they are going to see is that we are going to continue to play the game the way it has been played: Get the votes to defeat the amendment; we will take a little bit of heat; maybe somebody will notice. I will guarantee you, 20 years from now, our kids are going to notice, our grandkids are going to notice.

One final thought. If you are under 25 in this country, pay attention to me right now. If you are under 25—there are 103 million of you. Twenty years from now, you and your children will each be responsible for $1,919,000 worth of debt of this country for which you will have gotten no benefit—none. The cost to carry that will be about $70,000. That is not per family, that is per individual. The cost to carry that will be about $70,000 a year before you pay your first tax.

Ask yourself if you think we are doing a good job when we are going to take away your ability to get a college education, we are going to take away your ability to educate your children, when we are going to take away your ability to own a home, and we are going to take away your ability to have the capital formation to create jobs in this country. Watch and see. That number is going to grow every time we do something like this without paying for it, without offsets, without getting rid of something less important.

I yield back the time and yield the remainder of my time to the chairman of the committee.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make a point of clarification. This bill, the pending measure, is made up of two bills which is now S. 1963. It was S. 252, which was reported in July, and S. 801, which was reported in mid-October. Both bills were held at the time they went onto the calendar. No amendment was prepared to either bill. The first amendment was proposed on Monday of this week, 2 weeks after the bills were combined as S. 1963.

In closing, the debate about the United Nations is not one which belongs on a veterans bill. The underlying bill is a bipartisan approach to some of the most urgent issues facing all veterans—for women veterans, for homeless veterans, to help with quality issues, to help rural veterans.

This bill, by the way, also includes construction authorization for six major VA construction projects already funded by the VA spending bill.

I urge our colleagues to reject the amendment to S. 1963.

Mr. AKAKA. I yield back my time.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FRANKEN). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. LEAHY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. I thank the Chair.

EXECUTIVE SESSION

NOMINATION OF DAVID F. HAMILTON TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the following nomination, which the clerk will report.

The bill clerk read the nomination of David F. Hamilton, of Indiana, to be United States Circuit Judge for the Seventh Circuit.

Mr. LEAHY. Mr. President, is there a division of time in this matter?

The PRESIDING OFFICER. The time until 2:30 is equally divided.

Mr. LEAHY. Mr. President, I yield myself 10 minutes.

Mr. LEAHY. Mr. President, the Senate is concluding its long-delayed consideration of the nomination of Judge David Hamilton of Indiana to the Seventh Circuit. Early this week, 70 Senators—Democrats, Independents and Republicans—joined together to overcome a filibuster of this nomination. This has been a record year for filibusters by the Republican minority: filibusters of needed legislation, filibusters of executive nominations and filibusters of judicial nominations, which just a few years ago they proclaimed were ''unconstitutional.'' Although their filibuster failed, what they achieved was obstruction and delay. This is a nomination that has been stalled on the Senate Executive Calendar for 5½ months, since June 4. In the days since that bipartisan majority of 70 Senators voted to bring to an end the debate on the Hamilton nomination, and in the more than 30 hours of possible debate time since then, Republican Senators have devoted barely one hour to the Hamilton nomination. Only four Republican Senators have spoken at all and that includes the Senator from Alabama who repeated the claims he had made five times to the Senate since September 17.

As has been reported since the nomination was made in mid-March, President Obama's selection of Judge Hamilton as his first judicial nominee was intended to send a message of bipartisanship. President Obama reached out and consulted with both home State Senators, Senator LUGAR and Senator BAYH, a Republican and a Democrat, in making his selection. This stands in sharp contrast to the methods of his predecessor, who was focused on a narrow ideological effort to pack the Federal courts, often did not consult, and too often tried to force extreme candidates through the Senate. That is what led to filibusters—that and Senate Republicans changing of the rules, procedures and protocols of the Senate.

The nomination of Judge Hamilton is an example of that consultation. Other examples are the recently confirmed nominees to vacancies in South Dakota, who were supported by Senator THUNE, and the nominee confirmed to a vacancy in Florida, supported by Senators MARTINEZ and LEMIEUX. Still others are the President's nomination to the Eleventh Circuit from Georgia, supported by Senators ISAKSON and CHAMBLISS, his recent nominations to the Fourth Circuit from North Carolina, which I expect will be supported by Senator BURR, and the recent nomination to a vacancy in Alabama supported by Senators SHELBY and SESSIONS on which the Judiciary Committee held a hearing 2 weeks ago.

President Obama has respected the Senate's constitutional advice and consent role by engaging in meaningful consultation in making his judicial nominations. He has consulted with home State Senators from both sides of the aisle. This stands in sharp contrast to the methods of his predecessor, who was focused on a narrow ideological effort to pack the Federal courts, often did not consult, and too often tried to force extreme candidates through the Senate. That is what led to filibusters that and Senate Republicans changing of the rules, procedures and protocols of the Senate. In today's Washington Post, columnist E.J. Dionne writes about this occurrence and yesterday's failed attempt at a filibuster. I will ask that a copy of this column be printed in the RECORD.

Yet despite that consultation and the support and endorsement of the senior Republican in the Senate, Senator LUGAR, Republicans have filibustered and now oppose this nomination. Their response to President Obama's outreach and seeking to turn the page and set a new tone in judicial nominations by restoring comity is to attack his well qualified nominees and stall Senate action. In May, just before Judge Hamilton's nomination was reported by the committee, a senior Republican Senator reflected upon the Senate confirmation process for judicial nominees and correctly observed: ''[C]harges come flying in from right and left that are unsupported and false. It's very, very difficult for a nominee to push back. So I think we have a high responsibility to base any criticism that we have on a fair and honest statement of the facts and that nominees should not be subjected to distortions of their record.'' I agree.

Regrettably, however, that is not how Republican Senators have acted. Judge Andre Davis of Maryland, a distinguished African-American judge, was stereotyped as ''anti-law enforcement'' last week by Republican critics, and this week Judge Hamilton, the son of a Methodist minister, is reviled as hostile to Christianity. That is not fair treatment.

The unfair distortions of Judge Hamilton's record by right-wing special interest groups seeking to vilify him

have been repeated in editorials in the Washington Times and by Republican opponents in the Senate. They resort to twisting and contorting his judicial record and his views, and ignore the record before the Senate. Those distortions of Judge Hamilton's record were soundly refuted earlier this week by the senior Senator from Indiana, Senator LUGAR. I doubt that I will add to his sound and thoroughgoing rebuttal. Judge Hamilton's critics are wrong and have been wrong all along.

Senator LUGAR and Senator BAYH believe Judge Hamilton is superbly qualified and a mainstream jurist. I agree. Yet Republican critics of Judge Hamilton are determined to ignore the knowledge and endorsement of these home State Senators as well as Judge Hamilton's long, mainstream record on the bench to paint an unfair caricature of him. They are wrong to ignore Judge Hamilton's record of fairly applying the law in over 8,000 cases and his ''well qualified'' rating by the American Bar Association. These critics ignore Judge Hamilton's testimony before the committee when he said, ''I make decisions based on the facts and applicable law of each case.'' They ignore his statement that ''sympathy for one side or another'' in a case ''has no role in the process'' of judging. Instead, they construct and then seek to impose their own ''litmus tests'' and contort his record and statements in their ends-oriented effort to find him wanting.

Republican Senators did not object when Chief Justice Roberts testified at his confirmation hearing that ''of course, we all bring our life experiences to the bench.'' Republican Senators did not criticize Justice Alito at his confirmation hearings in 2006 for describing the importance of his background when evaluating discrimination cases. Justice Alito said: ''When I get a case about discrimination, I have to think about people in my own family who suffered discrimination because of their ethnic background or because of religion or because of gender. And I do take that into account.''

I recall one nominee who spoke during his confirmation hearing of his personal struggle to overcome obstacles. He made a point of describing his life as:

> [O]ne that required me to at some point touch on virtually every aspect, every level of our country, from people who couldn't read and write to people who were extremely literate, from people who had no money to people who were very wealthy. So, what I bring to this Court, I believe, is an understanding and the ability to stand in the shoes of other people across a broad spectrum of this country.

That is the definition of empathy. And that nominee was Clarence Thomas. Indeed, when President George H.W. Bush nominated Justice Thomas to the Supreme Court he touted him as, ''a delightful and warm, intelligent person who has great empathy and a wonderful sense of humor.'' Justice O'Connor, who had a long and distinguished record of evenhandedness on the Supreme Court, explained recently: ''You do have to have an understanding of how some rule you make will apply to people in the real world. I think that there should be an awareness of the real-world consequences of the principles of the law you apply.''

Yet now Republican Senators seek to apply a newly constructed ''litmus test'' that rejects what they had previously viewed as positive attributes as disqualifying. Their opposition to President Obama is so virulent that they act as if they must oppose anything he supports. If he sees value in judges with real world perspectives who consider the real impact of various readings of the law on everyday Americans, they must react in knee jerk opposition. They use a distorted lens to review a 15-year judicial record in which he has not substituted empathy for the law to somehow conclude that he will if confirmed to the new appointment. It is reminiscent of the Salem witch trials. They see what they want to see.

Senator LUGAR noted this week that the President of the Indiana Federalist Society endorsed Judge Hamilton as an ''excellent jurist and first-rate intellect'' with a judicial philosophy ''well within the mainstream.'' Senator LUGAR's own review of his record, with help from a former Reagan counsel, led him to conclude based on that record that ''Judge Hamilton has not been a judicial activist and has ruled objectively and within the judicial mainstream.'' Senator BAYH reinforced that conclusion with his statements in support of the nomination.

Republican critics are slavishly channeling the talking points of far right narrow special interest groups to twist a handful of the Judge Hamilton's 8,000 cases to make biased and unfair attacks on the character and record of a moderate judge and a good man. For example, they have misrepresented two of his cases, Hinrichs v. Bosma, 2005, and Grossbaum v. Indianapolis-Marion County Bldg. Authority, 1994, to falsely describe Judge Hamilton, the son of a Methodist minister, as hostile to religion, and to Christianity in particular. In fact, these cases show nothing more than that Judge Hamilton has consistently and objectively performed his duty as a judge to apply the law carefully to the case before him.

In Hinrichs v. Bosma, Judge Hamilton did not eliminate prayer, as some critics have charged. In fact, his narrow and carefully considered ruling was that the Indiana Legislature may begin its sessions with any non-denominational, nonsectarian prayers—prayers that do not advance a particular faith. He noted that those prayers ''must be non-sectarian and must not be used to proselytize or advance any one faith or belief or to disparage any other faith or belief.'' Prayers from any religion—be they Christian, Jewish, Muslim or from another religion—that advance a particular faith were not permissible.

The plaintiffs in Hinrichs had challenged the Christian orientation of most of the prayers delivered during the 2005 Indiana House session. So, as part of his analysis, Judge Hamilton reviewed the 45 available transcripts of the 53 opening prayers that were offered during that session. He relied on undisputed testimony of scholars and clerics of different faiths who themselves concluded that ''many of the legislative prayers delivered during the 2005 House session were sectarian, Christian in orientation, and sent a strong message of non-inclusion to those who are not Christian.'' His careful ruling did not depart from settled precedent. It followed the settled law from the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment of the Constitution.

The critics of Judge Hamilton who have made much of the fact that Judge Hamilton's decision was overturned by the Seventh Circuit ignore the fact that it was overturned only on the technical issue of standing, not on the merits of Judge Hamilton's opinion. In fact, even on this narrow technical point the Seventh Circuit initially upheld Judge Hamilton's 2005 decision that taxpayers had standing to sue the Indiana House of Representatives, challenging the practice of offering sectarian prayers at the beginning of sessions as a violation of establishment clause. The Seventh Circuit only reversed Judge Hamilton on this technical threshold question after the Supreme Court handed down an intervening 2007 decision, Hein v. Freedom from Religion Foundation, 2007, was issued after Judge Hamilton's decision was on appeal. In doing so, the Seventh Circuit acknowledged that it also was reversing its own previous decision in the case that affirmed Judge Hamilton's ruling that plaintiffs had standing.

These same critics have gone so far as to claim that Judge Hamilton favors Muslim prayers to Christian ones by allowing prayers to Allah, while forbidding prayers to Jesus Christ. This slur led to a Washington Times editorial denouncing the nomination. As Judge Hamilton explained in a ruling on a post-trial motion in Hinrichs, closely following Supreme Court precedent from Marsh v. Chambers, 1983, the mere use of the word for ''God'' in another language, such as the ''Arabic Allah, the Spanish Dios, the German Gott, the French Dieu, the Swedish Gud, the Greek Theos, the Hebrew Elohim, the Italian Dio'' does not make a prayer sectarian, because it does not ''advance a particular religion or disparage others.'' However, as Judge Hamilton testified in response to a question from Senator GRAHAM, under the reasoning of his ruling in Hinrichs, ''a prayer asserting that Mohammed was God's prophet would ordinarily be considered a sectarian Muslim prayer'' and impermissible.

Senators who charge that Judge Hamilton's ruling allows Muslim prayers whole forbidding Christian ones have either not read the case or choose to ignore what it says. Judge Hamilton's analysis of the 53 opening prayers that were offered in the Indiana House during the 2005 legislative session, found that all but one were delivered by Christian ministers or ministers identified with Christian churches. He noted that the one prayer that was not, which was delivered by a Muslim man, unlike the vast majority of the prayers from Christian clergy, was ''inclusive and was not identifiable as distinctly Muslim from its content.''

Judge Hamilton also faithfully applied binding precedent when deciding Grossbaum. In that case, Judge Hamilton correctly relied on then-current Supreme Court and Seventh Circuit precedent interpreting the free speech clause of the first amendment to reach his decision that the Indianapolis building authority acted lawfully in refusing to allow a rabbi to display a menorah in the lobby of the city-county building. His decision relied on a 1990 Seventh Circuit decision, Lubavitch Chabad House, Inc. v. City of Chicago, which upheld a decision by the city of Chicago to put a Christmas tree in the O'Hare Airport and, at the same time, to exclude private displays of religious symbols.

As with Hinrichs, right wing critics point to the Seventh Circuit's reversal of Judge Hamilton's decision to argue that he got it wrong and did not apply the law. What this account leaves out is that the Supreme Court case relied on by the Seventh Circuit to reverse Judge Hamilton did not come down until 1995, after Judge Hamilton issued his decision in Grossbaum. In reversing Judge Hamilton's decision, the Seventh Circuit specifically noted that Judge Hamilton acted without benefit of the Supreme Court's new guidance in this area provided by Rosenberger v. Rector & Visitors of the University of Virginia, 1995.

Had Judge Hamilton ignored the binding precedent in certain religion cases to make his decision based on personal beliefs and not the law, he would have been an activist going beyond his role as a district judge. As I read these cases, I had in mind the words of Senator LUGAR who said when he testified in support of Judge Hamilton:

> I have known David since his childhood. His father, Reverend Richard Hamilton, was our family's pastor at St. Luke's United Methodist Church in Indianapolis, where his mother was the soloist in the choir. Knowing first-hand his family's character and commitment to service, it has been no surprise to me that David's life has borne witness to the values learned in his youth.

Senator LUGAR knows Judge Hamilton's character. And the cases critics would use to savage it show nothing more than that Judge Hamilton understands, again in Senator LUGAR's words, ''the vitally limited, role of the Federal judiciary faithfully to interpret and apply our laws, rather than seeking to impose their own policy views.''

Critics have similarly twisted and disparaged Judge Hamilton's record on reproductive rights to paint him as an agenda-driven ideologue by pointing to a single case, A Woman's Choice v. Newman, 1995, even though in that case he carefully applied Supreme Court precedent.

In A Woman's Choice, Judge Hamilton blocked enforcement of part of an Indiana abortion law that required pregnant women to make two trips to a clinic before having an abortion. Judge Hamilton applied the law set forth by the Supreme Court in Planned Parenthood v. Casey, 1992, and, after carefully examining the facts, concluded that many Indiana women would not be able to make a second trip to a hospital or a clinic. Therefore, under the standard in Casey—the standard that Chief Justice Roberts and Justice Alito pledged to follow as binding precedent when nominees before the Judiciary Committee—Judge Hamilton concluded that the law undermined a woman's constitutionally protected right to choose.

Critics have seized on a split decision from the Seventh Circuit reversing Judge Hamilton's decision to grant a pre-enforcement injunction of the informed consent provision to mischaracterize his decisions in that case as activist. However, in reversing Judge Hamilton on the injunction, noted conservative icon Judge Easterbrook was criticized by another judge on the panel for ''disregard[ing] the standards that were established by the Supreme Court in [Casey]'' and was criticized for ''brush[ing] aside the painstakingly careful findings of fact'' that Judge Hamilton made. Even the concurring opinion recognized that Judge Easterbrook's opinion embraced dissenting opinions in other cases. Critics have also seized on a falsehood that Judge Hamilton blocked enforcement of the law for seven years, ignoring his modification of the initial injunction to permit Indiana to enforce most of its informed consent law after the Indiana Supreme Court ruled on a State law question of first impression that Judge Hamilton had certified so that he could be guided by the State's highest court on a question of State law, and ignoring Indiana's choice not to appeal Judge Hamilton's timely-issued decisions on the injunction until after trial, which Indiana had asked Judge Hamilton to postpone. Judge Hamilton's decisions in that case show that he was a careful judge showing appropriate deference to Indiana when addressing a matter of first impression in that State, not an ideologue or an activist.

Senators painting a false picture of Judge Hamilton's record have also cherry-picked his long record on the bench of handling criminal cases to focus on one or two cases they assert show that he is too lenient on criminals. Like the other charges against Judge Hamilton, this does not hold up to scrutiny. In his 15 years on the bench, the government has appealed only 2 of the approximately 700 criminal sentences Judge Hamilton has handed down. Judge Hamilton's critics ignore cases like U.S. v. Turner, 2006, in which Judge Hamilton sentenced a child pornographer to 100 years in prison. They ignore U.S. v. Clarke, 1999, in which Judge Hamilton sentenced a defendant to 151 months on three counts of drug distribution and an additional 60 months on a firearm charge, denying the defendant's motion for a reduced sentence citing the defendant's ''dangerous role in the distribution network.'' They ignore cases like U.S. v. Garrido-Ortega, 2002, in which Judge Hamilton sentenced a defendant to 70 months imprisonment for possession of counterfeit alien registration receipt cards and for being found in the United States as an alien previously deported after conviction, then denied the defendant's motion for reconsideration of sentence. They ignore decisions like U.S. v. Steele, 2009, U.S. v. Hagerman, 2007, and U.S. v. Ellis, 2007, in which Judge Hamilton imposed heavy sentences for drug dealing, obstruction of justice and for tax evasion. This charge against Judge Hamilton simply does not hold up.

Finally, we have heard repeatedly the falsehood that Judge Hamilton is an activist judge who will try to amend the Constitution through ''footnotes.'' However, Judge Hamilton testified in response to written questions from Senators that he believes that ''judges do not 'add' footnotes to the Constitution'' and that ''constitutional decisions must always stay grounded in the Constitution itself.''

In response to Senator SESSIONS, Senator GRASSLEY and others, Judge Hamilton wrote:

> The phrase ''footnotes to the Constitution,'' described by my late colleague Judge S. Hugh Dillin, refers to the case law interpreting the Constitution. By that phrase, I believe he meant that the general provisions of the Constitution take on their life and meaning in their application to specific cases, that the case law is not the Constitution itself, and that constitutional decisions must always stay grounded in the Constitution itself. In my view, judges do not ''add'' footnotes to the Constitution itself. They apply the Constitution to the facts of the particular case and add to the body.

Further, in response to another question from Senator SESSIONS, Judge Hamilton testified: ''I have not added footnotes to the Constitution. I believe the constitutional decisions I have made have been consistent with the express language and original intent of the Founding Fathers.'' I am hard-pressed to understand why Senators would ask such questions if they do not consider the nominee's clear answers.

I hope that Senators now considering whether to support this well-qualified mainstream nominee resist the partisan effort to build a straw man out of one or two opinions in a 15-year record

on the bench. I hope they do not allow right wing talking points to overshadow Judge Hamilton's long and distinguished record on the bench. Instead, I urge Senators to heed the advice of Senator LUGAR who urged that ''confirmation decisions should not be based on partisan considerations, much less on how we hope or predict a given judicial nominee will 'vote' on particular issues of public moment or controversy.''

This is a nomination that should be confirmed and should have been confirmed months ago. David Hamilton is a fine judge and will make a good addition to the United States Court of Appeals for the Seventh Circuit.

Mr. President, I ask unanimous consent to have a copy of the Washington Post article to which I referred printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Washington Post, Nov. 19, 2009]

THE GOP'S NO-EXIT STRATEGY

(By E.J. Dionne, Jr.)

Normal human beings—let's call them real Americans—cannot understand why, 10 months after President Obama's inauguration, Congress is still tied down in a procedural torture chamber trying to pass the health-care bill Obama promised in his campaign.

Last year, the voters gave him the largest popular-vote margin won by a presidential candidate in 20 years. They gave Democrats their largest Senate majority since 1976 and their largest House majority since 1992.

Obama didn't just offer bromides about hope and change. He made specific pledges. You'd think that the newly empowered Democrats would want to deliver quickly.

But what do real Americans see? On health care, they read about this or that Democratic senator prepared to bring action to a screeching halt out of displeasure with some aspect of the proposal. They first hear that a bill will pass by Thanksgiving and then learn it might not get a final vote until after the new year.

Is it any wonder that Congress has miserable approval ratings? Is it surprising that independents, who want their government to solve a few problems, are becoming impatient with the current majority?

Democrats in the Senate—the House is not the problem—need to have a long chat with themselves and decide whether they want to engage in an act of collective suicide.

But it's also time to start paying attention to how Republicans, with Machiavellian brilliance, have hit upon what might be called the Beltway-at-Rush-Hour Strategy, aimed at snarling legislative traffic to a standstill so Democrats have no hope of reaching the next exit.

We know what happens when drivers just sit there when they're supposed to be moving. They get grumpy, irascible and start turning on each other, which is exactly what the Democrats are doing.

Republicans know one other thing: Practically nobody is noticing their delay-to-kill strategy. Who wants to discuss legislative procedure when there's so much fun and profit in psychoanalyzing Sarah Palin?

Yet there was a small break in the Curtain of Obstruction this week when Republican senators unashamedly ate every word they had spoken when George W. Bush was in power about the horrors of filibustering nominees for federal judgeships. On Tuesday, a majority of Republicans tried to block a vote on the appointment of David F. Hamilton, a rather moderate jurist, to a federal appeals court.

Sen. Jeff Sessions of Alabama explained the GOP's about-face by saying: ''I think the rules have changed.''

That was actually a helpful comment, because the Republicans have changed the rules on Senate action up and down the line. Hamilton's case is just the one instance that finally got a little play.

Thankfully, this filibuster failed because some Republicans were embarrassed by it. But Republican delaying tactics have made Obama far too wary about judicial nominations for fear of controversy. He is well behind his predecessor in filling vacancies, a shameful capitulation to obstruction. There's also the fact that the nomination of Christopher Schroeder as head of the Justice Department's Office of Legal Policy, which helps to vet judges, is snarled—guess where?—in the Senate.

Republicans are using the filibuster to stall action even on bills that most of them support. Remember: The rule is to keep Democrats from ever reaching the exit.

As of last Monday, the Senate majority had filed 58 cloture motions requiring 32 recorded votes. One of the more outrageous cases involved an extension in unemployment benefits, a no-brainer in light of the dismal economy. The bill ultimately cleared the Senate this month by 98 to 0.

The vote came only after the Republicans launched three filibusters against the bill and tried to lard it with unrelated amendments, delaying passage by nearly a month. And you wonder why it's so hard to pass health care?

Defenders of the Senate always say the Founders envisioned it as a deliberative body that would cool the passions of the House. But Sessions unintentionally blew the whistle on how what's happening now has nothing to do with the Founders' design.

The rules have changed. The extra-constitutional filibuster is being used by the minority, with extraordinary success, to make the majority look foolish, ineffectual and incompetent. By using Republican obstructionism as a vehicle for forcing through their own narrow agendas, supposedly moderate Democratic senators will only make themselves complicit in this humiliation.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, we moved three judges through committee today, and I think, all in all, Senator LEAHY is working us to death. But we are making some progress.

I would note for the record, if anybody would like to know, there are 21 circuit vacancies for circuit courts in America. The President has nominated 10 people for those vacancies. There are 76 district court vacancies, and as of November 16 the President has nominated 10. He has more vacancies than President Bush had at this time and he has nominated fewer people. But a lot of things are happening. They will catch up. You have to do backgrounds on nominees, and they should not just throw up names for the sake of throwing up names.

Most of his nominations are receiving bipartisan support. Unfortunately, I have not been able to support Judge Hamilton, and I would like to explain a few of the things that concern me, particularly about his judicial philosophy and about his rulings. I think they are significant. I wish they weren't. He is not a bad person, but a lot of people in America today have a philosophy that I think is not appropriate for the Federal bench.

In Hinrichs v. Bosma, Judge Hamilton enjoined or issued an order prohibiting the speaker of the Indiana House of Representatives, the duly elected speaker, from allowing a sectarian prayer, as he described it, because some of those prayers had mentioned Jesus Christ and therefore ''might advance a particular religion, contrary to the mandates of the Constitution.''

Judge Hamilton also ordered the speaker to make sure to advise any officiant who is delivering a prayer that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use ''Christ's name or title or any other denominational appeal.''

I note parenthetically that every day we have a paid chaplain who commences the Senate with a prayer. Heaven knows we need it. Hopefully we recognize we need it. I notice the words up there on the wall, ''In God We Trust,'' haven't been chiseled out by the secularists as of this date. We are a nation that believes in freedom of religion, and the Constitution says Congress shall make no law respecting the establishment of a religion or prohibiting the free exercise thereof. We have ceased to balance that out, in my opinion, in some of these matters.

So he made that ruling and that injunction to the speaker. In a later ruling denying the speaker's request to stay this injunction, Judge Hamilton produced a novel notion that prayers in the name of Jesus would be sectarian and, therefore, prohibited, but prayers in the name of Allah would not be sectarian and, therefore, would be allowed. They had an Islamic imam pray there in Indiana.

This is what Judge Hamilton wrote:

> Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Saviour, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine.

He went on to say:

> If those offering prayers in the Indiana House of representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

In other words, that would be OK. I find it hard to justify that position intellectually, frankly. I am not saying he is anti-religion. I am saying this judge's approach to the law is confused about an important legal question involving religion.

The Seventh Circuit reversed Judge Hamilton, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did

Judge Hamilton skip over the very basic preliminary legal issue of standing and instead move directly to the merits of the case, if the standing didn't exist? I submit he perhaps desired to rule on the merits because he favored the outcome he produced.

In A Woman's Choice v. Newman, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years, an Indiana law. In 1995, the Indiana Legislature enacted a statute that required certain medical information to be provided to women seeking an abortion at least 18 hours prior to the procedure. The Supreme Court, in Planned Parenthood v. Casey, a very important case, had already held very similar requirements were constitutional and did not restrict the right to an abortion. It just required that the information provided to you 18 hours in advance. Notwithstanding the Supreme Court precedent, Judge Hamilton granted a preliminary injunction against enforcement of the law. In other words, he stopped the law from going into effect. He assumed the role of a legislator. He took out his judicial pen and struck some of the language from the statute, language he didn't like.

The statute required that women receive this information in person, not through some third person. Judge Hamilton modified the injunction so as to prevent the State from enforcing the requirement that the information be provided ''in the presence of'' the pregnant woman. He later entered a permanent injunction that prohibited enforcement of the law, in essence vetoing the law.

Finally, the case reached the Seventh Circuit. In an opinion by Judge Easterbrook, the court reversed, concluding that Judge Hamilton had abused his discretion. A Federal judge with a lifetime appointment has power over the States. If he says the Constitution is violated by what a State does, the judge has the power to invalidate what the State does. But this is an awesome power and ought to be used carefully. When this case reached the Seventh Circuit, this is what the opinion said:

> [F]or 7 years, Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

If it is a bad law, the people would change it. They have the power to do so.

I suggest that is a pretty stark criticism and a very serious one. One single judge has frustrated a law that was constitutional for 7 years.

In U.S. v. Woolsey, Judge Hamilton disregarded a defendant's prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence of life imprisonment for persons convicted of a third felony drug offense. Here the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine—and that is a lot of methamphetamine—a cache of guns, and $16,000 in currency. Because the defendant had two prior felony drug convictions, the defendant was subject to recidivism penalties under Federal law. Judge Hamilton was reversed because he ignored one of those prior convictions, reversed unanimously by the circuit court on which he now wants to sit.

This is what they said about his willfulness:

> [W]e have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deemed them unwise or an inappropriate response to repeat drug offenders.

They were saying: Judge, you have been letting your own personal views override what you are required to do by the law. You are a judge. You are supposed to follow the law. The oath you take is to serve under the Constitution and the laws of the United States. You are not above it.

The opinion makes clear that Judge Hamilton either made several unnecessary errors or intentionally ignored the law.

In Grossbaum v. Indianapolis-Marion County Building Authority, Judge Hamilton denied a request by a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Judge Hamilton's ruling, noting that two Supreme Court cases were directly on point.

For 8 years the plaintiff in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violative of the first amendment. Because of the ACLU's challenge in 1993, Marion County unanimously adopted a ''policy on seasonal displays.'' They set up a policy to try to make everybody happy. It was done to try to keep the courts happy by preventing a menorah from being displayed.

In 1994, when the plaintiffs submitted a request to display the menorah, they were denied.

Mr. President, I know my time is up, and I ask unanimous consent for 1 additional minute.

Mr. LEAHY. Provided there is another minute on this side.

Mr. SESSIONS. I understand.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, there are other matters that I don't have time to go into in detail. Any nominee is entitled to a fair hearing. They ought not have their record distorted. As the Senator said, people can make mistakes sometimes. But I think the pattern is such that it indicates to me there are extraordinary circumstances that justify an objection to the nomination because the nominee has shown a willfulness to override the law. A judge must be under the law.

I offer the following more detailed explanation to try to go into even more detail and to fairly analyze the judge's rulings and why I think they are unacceptable.

There have been some accusations that we have mischaracterized Judge Hamilton's record, and, specifically, some of his cases. I would like to take just a few moments to explain why I am concerned about Judge Hamilton's judicial philosophy and demonstrate how we have not mischaracterized his rulings.

In *Hinrichs* v. *Bosma*, 400 F. Supp. 2d 1103, S.D. Ind. 2005, the Indiana ACLU, representing some taxpayers, brought suit against the Speaker of the Indiana House of Representatives claiming that ''most'' of the prayers that opened legislative sessions were sectarian Christian prayers in violation of the first amendment. Although 29 out of 45 of the prayers for which there were transcripts were Christian, many prayers were offered by state legislators, a rabbi, and a Muslim imam.

Nevertheless, Judge Hamilton enjoined the speaker from allowing sectarian prayers because some of them mentioned Jesus Christ and therefore might ''advance a particular religion, contrary to the mandate of the Establishment Clause.'' Judge Hamilton also ordered the speaker to advise any officiant that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use ''Christ's name or title or any other denominational appeal.''

In so holding, Judge Hamilton relied on what I think is a flawed reading of the Supreme Court's decision in *Marsh* v. *Chambers*, 463 U.S. 783, 1983, which held that a legislative body may open its session with a prayer, much like we do here in the Senate every day. Judge Hamilton said that the *Marsh* case did not expressly permit prayers that were ''explicitly Christian or explicitly Jewish.'' But the Supreme Court in *Marsh* said:

> The content of the prayer is not of concern to judges where . . . there is no indication that the prayer opportunity has been exploited to proselytize or advance any one, or to disparage any other, faith or belief. That being so, it is not for us to embark on a sensitive evaluation or to parse the content of a particular prayer.

Judge Hamilton ignored the Supreme Court's clear directive that the content of such prayers should not be of concern to a judge. He had no concerns about whether he would parse through the content by dictating from the bench what constitutes sectarian prayer. In fact, in a later ruling denying the speaker's request to stay the permanent injunction, Judge Hamilton came up with the radical notion that prayers in the name of Jesus Christ would be sectarian and therefore prohibited, but prayers in the name of Allah would not

be sectarian and therefore allowed. He said:

> Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Savior, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine. . . .

He went on to say:

> If those offering prayers in the Indiana House of Representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

I find it hard to believe that anyone would not associate a reference to Allah with Islam.

After full briefing and oral argument, the Seventh Circuit reversed Judge Hamilton's decision, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did Judge Hamilton skip over the very basic, preliminary issue of standing and instead move directly to the merits of this case? I submit that Judge Hamilton wanted to get to the merits because he sought this particular outcome.

In *A Woman's Choice* v. *Newman*, 904 F. Supp. 1434, S.D. Ind. 1995, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years. In 1995, the Indiana legislature enacted a statute that required women seeking an abortion to receive certain medical information at least 18 hours prior to the abortion being performed. Specifically, the statute required that the women be informed of the following information:

1. The name of the physician performing the abortion.
2. The nature of the proposed procedure or treatment.
3. The risks of and alternatives to the procedure or treatment.
4. The probable gestational age of the fetus.
5. The medical risks associated with carrying the fetus to term.
6. The availability of fetal ultrasound imaging.
7. That medical assistance benefits may be available for prenatal care . . . from the county office of the division of family resources.
8. That the father of the unborn fetus is legally required to assist in the support of the child.
9. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

The Supreme Court in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 1992, had already held that very similar requirements did not restrict the access to abortions and that is an important point here.

Despite the Casey decision, and an almost identical Seventh Circuit opinion upholding a Wisconsin statute, the plaintiffs filed a lawsuit challenging the constitutionality of the Indiana law on the grounds that it was likely to impose an undue burden on a woman's right to choose. I am not sure how knowing the name of the doctor who is performing an abortion imposes an undue burden. In support of their argument, the plaintiffs presented evidence that the law was likely to prevent abortions for approximately 11 to 14 percent of women who would otherwise choose to have them and the ''medical emergency'' exception would probably fail to meet constitutional standards as unduly narrow.

Judge Hamilton granted the plaintiffs a preliminary injunction with certified questions to the Supreme Court of Indiana concerning the interpretation of the ''medical emergency'' exception under State law.

The Indiana Supreme Court answered the certified questions and basically held that Indiana's law did not violate the Supreme Court holding in Casey. The Indiana Supreme Court concluded:

> the medical emergency provision of Public Law 187 permits dispensing with the informed consent requirements when the attending physician, in the exercise of her clinical judgment in light of all factors relevant to a woman's life or health, concludes in good-faith that medical complications in her patient's pregnancy indicate the necessity of treatment by therapeutic abortion. We add that the physician may do so with respect to serious and permanent mental health issues. A physician may not, however, dispense with the informed consent provisions as to health problems when they are temporary.

This holding by the Indiana. Supreme Court should have resolved the matter.

Notwithstanding, Judge Hamilton assumed the role of a legislator, took out his judicial pen and struck some language from the Indiana statute. The statute required that women receive this information in person. Judge Hamilton modified the preliminary injunction that he had issued so as to prevent the State from enforcing the requirement that the information be provided ''in the presence'' of the pregnant woman. Judge Hamilton later entered a permanent injunction that prohibited enforcement of the law—in essence vetoing the law.

Finally, the case reached the Seventh Circuit, which reversed Judge Hamilton's ruling. In a 2–1 opinion by Judge Easterbrook, the court concluded that Judge Hamilton abused his discretion:

> [F]or seven years Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

In a concurring opinion, Judge Coffee concluded:

> [Judge Hamilton's opinion which was] pronounced without the support of even one citation to the record, invades the legitimate province of the legislative and executive branches and places a straitjacket upon their power to regulate and control abortion practice. As a result, literally thousands of Indiana women have undergone abortions since 1995 without having had the benefit of receiving the necessary information to ensure that their momentous choice is premised upon the wealth of information available to make a well-informed and educated life-or-death decision. I remain convinced that [Judge Hamilton] abused his discretion when depriving the sovereign State of Indiana of its lawful right to enforce the statute before us. I can only hope that the number of women in Indiana who may have been harmed by the judge's decision is but few in number.

Three different courts, including the Indiana Supreme Court, had looked at the Indiana statute and similar laws and concluded they passed constitutional muster. This apparently did not satisfy Judge Hamilton and so he ignored the precedent and ruled based on his own policy preferences.

In *United States* v. *Woolsey*, 535 F.3d 540 (7th Cir. 2008), Judge Hamilton disregarded a defendant's prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence of life imprisonment for persons convicted of a third felony drug offense. Judge Hamilton was reversed by a unanimous Seventh Circuit:

> [W]e have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deems them unwise or an inappropriate response to repeat drug offenders.

Here, the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home, where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine, a cache of guns and $16,000 in currency. Because the defendant had two prior felony drug convictions in 1997 and 1974, the defendant was subject to recidivism penalties under Federal statute.

At sentencing, the government properly filed an enhancement information detailing the two prior convictions, which should have triggered a mandatory term of life imprisonment. Although the defendant conceded that his 1997 drug conviction would count for enhancement purposes, he contested the eligibility of the 1974 conviction. The defendant argued that he believed the 1974 conviction—possession with intent to distribute 125 pounds of marijuana—should have been set aside upon successful completion of his probation pursuant to the Federal Youth Corrections Act. The Federal Youth Corrections Act allows previous sentences to be set aside in cases where there was an early discharge of probation and where the probationer had ''demonstrate[ed] good behavior to the sentencing court before the probationary period ended.''

Here, the Arizona district court that had sentenced the defendant did not grant the early discharge. The defendant claimed this was an oversight, so Judge Hamilton postponed the defendant's sentencing to give him a chance to petition the Arizona court to have the 1974 conviction cleared. According to the opinion reversing Judge Hamilton, ''the Arizona court was not inclined to grant the request.'' We know

the defendant had another conviction beyond 1974, so perhaps he did not meet the good behavior requirement.

The Seventh Circuit also noted that the Federal statute:

bars any challenge to the validity of any prior conviction alleged under this section which occurred more than five years before the date of the information alleging such prior conviction . . . [The defendant] never denied the 1974 conviction, and the five-year window closed some time ago.

At sentencing, Judge Hamilton chose to disregard the 1974 conviction and not impose a life sentence. He stated:

I believe it is also appropriate under these circumstances to not count the 1974 marijuana conviction for this purpose. On that issue, with respect to both the guidelines and the [federal statute], I will say that it seems to me that there is no apparent reason in this record why the defendant should not have been discharged early as to what is the customary practice as was intended and, in essence, the Court ought to treat as having been done what should have been done under general equitable powers.

The Seventh Circuit vacated the sentence and admonished Judge Hamilton: ''[the] Indiana district court was not free to ignore Woolsey's earlier conviction. . . . as Tuten makes clear, the court that imposed a sentence under the YCA should be the one to exercise the discretion afforded by the Act.'' The court further stated:

sentencing is not the right time to collaterally attack a prior conviction unless the prior conviction was obtained in violation of the right to counsel-which [the defendant] does not suggest. . . . Accordingly, the decision to disregard [the defendant's] prior conviction in light of what the court believed 'should have been done' three decades earlier was incorrect.

I think this opinion makes it clear that Judge Hamilton either made several unnecessary errors in his ruling or intentionally ignored the rule of law because he did not like the sentence. I believe it was the latter of the two.

In *Grossbaum* v. *Indianapolis-Marion County Building Authority*, 870 F. Supp. 1450 (S.D. Ind. 1994), Judge Hamilton denied a request by a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Hamilton's ruling and noted that two Supreme Court cases were directly on point.

For 8 years the plaintiffs in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violative of the First Amendment. Because of the ACLU's challenge, in 1993 Marion County unanimously adopted a ''policy on seasonal displays'' that prevented the menorah from being displayed. So in 1994 when the plaintiffs submitted a request to display the menorah, their request was denied. The plaintiffs responded by filing a motion for a preliminary injunction to require the county building manager to allow them to display a menorah in the non-public-forum lobby of the building, something they had been allowed to do every holiday season between 1985 and 1992.

Judge Hamilton denied the motion, stating that the First Amendment's free speech clause did not require Marion County to allow the display and that the county was reasonable in believing the establishment clause prohibited it from doing so. He refused to apply controlling Supreme Court precedent and instead embraced what appears to be an evolving standard based on something other than the law. He said: ''[o]ne of the challenges . . . is to keep the structure of abstract analytic categories and logical tests in touch with the practical realities before the courts.''

Judge Hamilton also ruled that Marion County's policy was a permissible ''subject matter restriction'' under the first amendment, rather than prohibited ''viewpoint discrimination.'' Specifically, he decided that the county could put up its own ''secular holiday symbol,'' a Christmas tree, while excluding anyone from expressing a religious view of the holiday season. He then concluded that the county could choose to avoid the controversy that might be provoked by the display of religious symbols and that ''practical considerations'' justified his reading of the Constitution. Indeed, Judge Hamilton stated that the plaintiff's position could not be correct because, if it were, the result would be that:

every time a government [put] up a Christmas tree (or perhaps a wreath or some evergreen branches) in a ''nonpublic forum,'' that government [would have] extended an open invitation to all interested private parties to display the religious symbols of their choice in the same area. As a practical matter, that result would be dramatic.

In an opinion by Judge Ripple, the Seventh Circuit unanimously reversed. The court rejected Judge Hamilton's attempts to distinguish the case from the Supreme Court's decisions in Rosenberger and Lamb's Chapel, holding that the prohibition of the menorah's message because of its religious perspective was unconstitutional viewpoint discrimination. The court found that the county's policy:

''clearly concerns 'seasonal displays' in its government building. The policy . . . clearly is a prohibition of one type of seasonal display, namely religious displays and symbols.''

The Seventh Circuit also said:

the court's colloquy with counsel at oral argument made it quite clear that the policy challenged here was to prevent one thing: seasonal holiday displays of a religious character.

Because neutrality and equal access to the nonpublic forum lobby avoided establishment clause problems, the Seventh Circuit held the county's establishment clause defense was insufficient.

The Seventh Circuit saw very clearly what Judge Hamilton seems to have been far too distracted by ''practical realities'' to realize—that the government policy in question was based solely on the viewpoint expressed and, thus, was unconstitutional. Judge Hamilton, by all accounts, has a talented legal mind. Therefore, I can only conclude that the ''practical reality'' Judge Hamilton was so concerned with was, in fact, the result he wanted to reach.

Finally, in *United States* v. *Rinehart*, 2007 U.S. Dist. LEXIS 19498, S.D. Ind. February 2, 2007, the defendant, a police officer who filmed himself having sex with a minor and took pictures of another minor, pled guilty to two counts of producing child pornography. Although Judge Hamilton sentenced him to the mandatory minimum of 15 years in prison, he took the highly unusual step of issuing a separate written opinion ''so that it may be of assistance in the event of an application for executive clemency,'' an action that Judge Hamilton called ''appropriate.''

The defendant, a 32-year-old cop, engaged in ''consensual'' sexual relations with two young girls, ages 16 and 17. According to Judge Hamilton's opinion, the sexual relationships were legal under State and Federal law. However, the defendant took photos and videos of himself and the girls engaged in ''sexually explicit conduct'' and sexual relations. These images were found on his home computer and he was charged under the Child Protection Act of 1984.

In his written opinion, Judge Hamilton noted his disapproval of the mandatory minimum and concluded by expressly injecting his personal views into the case:

This case, involving sexual activity with victims who were 16 and 17 years old and who could and did legally consent to the sexual activity, is very different. But because of the mandatory minimum 15 year sentence required by [the Child Protection Act of 1984] this court could not impose a just sentence in this case. The only way that Rinehart's punishment could be modified to become just is through an exercise of executive clemency by the President. The court hopes that will happen.

That last sentence embodies precisely the type of activist philosophy that I have been talking about. But here, we do not need to read between the lines. We do not need to infer a thing. Judge Hamilton laid it on in an opinion. And the opinion had the express aim of urging the executive to adopt his policy preferences. When a judge steps outside of his coinstitutional role of interpreting and applying the law as written, he undermines the entire justice system.

These are just a few of the problematic cases in Judge Hamilton's record. To date, the Seventh Circuit has been able to reverse these errors, but if he is elevated, only the Supreme Court will be able to reverse most of his errors. I am afraid the Supreme Court might not hear some of them. This body should elevate those judges who have performed admirably during lower court service, not those who have performed poorly.

I yield the floor.

Mr. CORNYN. Mr. President, I will not support Judge David Hamilton's elevation to the Court of Appeals for the Seventh Circuit. After close review, I believe Judge Hamilton's writings

and statements show an unwillingness to serve as a neutral arbiter of the law.

At the time he was appointed to the district court for the Southern District of Indiana, the American Bar Association rated Judge Hamilton ''not qualified.'' This rating is still apt.

In numerous opinions written during his tenure on the district court, Judge Hamilton has displayed a lack of impartiality, a disregard for precedent, and a willingness to legislate from the bench. His writings also evince his propensity to value ''an understanding of the world from another's point of view'' above an understanding of the facts of a case.

For instance, in striking down Indiana's popularly enacted informed-consent abortion law, Judge Hamilton radically ruled that the law unconstitutionally imposed an ''undue burden'' on the right to an abortion because it qallegedly forced ''women to make two trips to a clinic.'' *A Woman's Choice* v. *Newman*, 132 F.Supp.2d 1150, 1151, S.D. Ind. 2001. In making this ruling, Judge Hamilton flaunted the directly applicable precedents of the Supreme Court and the Seventh Circuit. He also, according to Seventh Circuit opinion that reversed his ruling, relied on a ''faulty study by biased researchers who operated in a vacuum of speculation.'' *A Woman's Choice* v. *Newman*, 305 F.3d 684, 689, 7th Cir. 2002.

Similarly, in a case where a child's complaint to school officials about her mother's drug abuse led to the mother's arrest, Judge Hamilton suppressed the drug evidence against the mother on the ground that the police had violated her substantive due process right to ''family integrity.'' *United States* v. *McCotry*, 2006 U.S. Dist. LEXIS 62777, S.D. Ind., July 13, 2006. To reach this conclusion, Judge Hamilton ignored controlling Seventh Circuit law and relied instead on the dissenting opinions of Ninth Circuit judges. And when the Seventh Circuit reversed Judge Hamilton, it chastised him for not properly considering the wrongs of the mother in the case, who ''risked her relationship with her nine-year old daughter by dealing drugs.'' *United States* v. *Hollingsworth*, 495 F.3d 795, 803 n.3, 7th Cir. 2007.

In these cases, and many more, Judge Hamilton has shown an unvarnished result-orientation and has confirmed his reputation as ''one of the more liberal judges in the district.'' Almanac of the Federal Judiciary. This record has not earned him the honor of elevation to a higher court.

As President Obama's first nominee, there is no doubt that Judge Hamilton possesses the empathy and desire to write ''footnotes to the Constitution'' that catch the eye of liberal activists and partisan politicians. But these qualities are not ones that a Circuit Judge of the United States should possess. Accordingly, I will vote no on the confirmation of Judge David Hamilton.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, as I sit here and listen, I wonder who in Heaven's name they are talking about. Judge Hamilton had 8,000 cases. Apparently, there is no problem with any of them except for a tiny handful of cases, and those have been so distorted by Judge Hamilton's opponents that I don't even understand them. Basically, I think they are saying what he should have done is gone by his personal beliefs and not the law. Of course, then they could say he was an activist judge.

He is in a situation where they will try and get him either way. A judge can follow the law, do what they are supposed to do, try 8,000 cases, get strong support from people from the right to the left, and get the highest possible rating a judge can get. But don't worry. We are going to take some case or two out of context from their 15 years on the bench. We will ignore 8,000 cases. We will call them a gender-driven ideologue. We will point to a single case, even though in that case they carefully applied Supreme Court precedent.

Come on. Let's be fair. Eight thousand cases, the highest rating possible, endorsed by everybody who knows him, and strongly backed by Senators LUGAR and BAYH. Judge Hamilton is not an ideologue. Apparently, there is no problem with any of his 8,000 cases except a couple that people have taken out of context. We should be the conscience of the Nation. We are above that, and we should vote for his confirmation.

AMENDMENT NO. 2785

Mr. President, I also want to take a couple of minutes to speak against Senator COBURN's amendment to the veterans health bill we will be voting on shortly.

Senator AKAKA has already explained that we do not need the Coburn amendment to fund the programs in this veterans health bill. So do not be misled by the suggestion that we need to cut funding for the United Nations to care for our veterans. That is a false choice.

This is nothing more than a ploy to take a swipe at the United Nations. Senator COBURN spoke earlier, and his statement consisted of a laundry list of factual inaccuracies about the United Nations.

Is the United Nations perfect? Far from it. But legitimate criticism is one thing. Inventing facts is another. To say that the U.N. Development Program provided millions of dollars to North Korea which used the funds to ''purchase conventional arms and ballistic missiles,'' when there is no proof of that, does not belong in this debate..

I would say to those Senators who think the United States should not fulfill its treaty obligations to the United Nations, who think we should renege on our commitments to support U.N. peacekeeping missions, and who favor walking away from our pledges to NATO, the International Atomic Energy Agency, the World Health Organization, and many other organizations we were instrumental in creating, then vote for this misguided amendment.

But if Senators believe that United States leadership in the world means paying our share and being able to use our influence, then I urge Senators to oppose it.

Our assessed contributions to the United Nations, which the Coburn amendment would cut, support a wide range of activities that advance our own national interests. That was as true during the Bush Administration, which would have opposed this amendment, as it is today. The State Department opposes this amendment.

Here are some examples of what the funds are used for by the U.N. and other international organizations that Senator COBURN's amendment would cut:

Preparing for and holding elections in Iraq.

Monitoring nuclear programs in North Korea and Iran. Do we really want to cut funding for the international nuclear inspectors who Iran finally allowed into one of their facilities?

Supporting NATO. I can't imagine any Senator wants to cut our contribution to NATO, when we are asking our NATO allies to do more in Afghanistan.

Funding 17 U.N. peacekeeping missions, including in Haiti, Liberia, Lebanon, Darfur and the Congo. We don't contribute troops for these missions other nations like Bangladesh and Morocco do. But they rely on us to pay our share of the cost, and it is a lot less expensive than sending our own troops.

Supporting the Food and Agriculture Organization's forecasts of global food production, identifying areas of drought and famine, to provide emergency food assistance.

Coordinating tsunami and earthquake relief in Indonesia and Pakistan.

Supporting the World Health Organization's work to detect outbreaks of avian flu and Swine Flu and other infectious diseases and defending against a world pandemic.

Creating and maintaining protections for the intellectual property rights of American companies.

Coordinating international aviation safety standards.

Coordinating efforts by the global shipping industry and governments to prevent and respond to acts of piracy on the high seas.

These are organizations that are advancing our own interests.

President Obama has stated his commitment that the U.S. will pay its dues to U.N. peacekeeping and international organizations. The Appropriations Committee has acted on that commitment. We are once again in good financial standing at the United Nations. This amendment would put us back in arrears.

Our dues to the United Nations and other international organizations are treaty obligations. Not paying is not an option.

Let's stop acting like the United States doesn't matter. Let's not say that because the U.N. isn't perfect, we should cut our dues.

We are the world's leading military and economic power, and there is much we can achieve on our own. But we cannot stop genocide in Darfur alone any more than we can stop the spread of HIV/AIDS without the cooperation of other nations.

We need to lead by example in the United Nations, in NATO, at the World Health Organization, the International Atomic Energy Agency, the Organization for the Prevention of Chemical Weapons, the Food and Agriculture Organization, the World Intellectual Property Organization. We can't do that without paying what we owe.

This body has already voted for the funds to support United Nations peacekeeping and these international organizations. Senator COBURN's amendment would cut those funds.

I also want to set the record straight on another misstatement of Senator COBURN's. He said his amendment to the fiscal year 2008 State and Foreign Operations appropriations bill was unanimously passed and then dropped in conference. It was not dropped in conference.

His amendment would have withheld all U.S. contributions to international organizations. The House and Senate conferees did not support that. What emerged from conference was a 10 percent withholding of funds, still tens of millions of dollars, tied to audits, budget reports, and oversight. It also withheld 20 percent of the U.S. contribution to the U.N. Development Program.

Was it everything Senator COBURN wanted? No. Was it dropped in conference? No. The substance of his amendment was included in the conference agreement, and for the benefit of anyone who cares to read it, it is section 668 of Public Law 110–161.

I agree with Senator AKAKA and urge Senators to oppose the Coburn amendment.

Mr. President, I strongly join Senators LUGAR and BAYH in the support of Judge Hamilton.

I yield back any time.

The PRESIDING OFFICER (Mr. BEGICH). All time is expired.

The question is, Will the Senate advise and consent to the nomination of David F. Hamilton, of Indiana, to be U.S. circuit judge for the Seventh Circuit?

Mr. LEAHY. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS), and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 59, nays 39, as follows:

[Rollcall Vote No. 350 Ex.]

YEAS—59

Akaka	Hagan	Murray
Bayh	Harkin	Nelson (NE)
Begich	Inouye	Nelson (FL)
Bennet	Johnson	Pryor
Bingaman	Kaufman	Reed
Boxer	Kerry	Reid
Brown	Kirk	Rockefeller
Burris	Klobuchar	Sanders
Cantwell	Kohl	Schumer
Cardin	Landrieu	Shaheen
Carper	Lautenberg	Specter
Casey	Leahy	Stabenow
Conrad	Levin	Tester
Dodd	Lieberman	Udall (CO)
Dorgan	Lincoln	Udall (NM)
Durbin	Lugar	Warner
Feingold	McCaskill	Webb
Feinstein	Menendez	Whitehouse
Franken	Merkley	Wyden
Gillibrand	Mikulski	

NAYS—39

Alexander	Crapo	LeMieux
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Inhofe	Thune
Collins	Isakson	Vitter
Corker	Johanns	Voinovich
Cornyn	Kyl	Wicker

NOT VOTING—2

Baucus	Byrd

The nomination was confirmed.

The PRESIDING OFFICER. The President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009—Continued

AMENDMENT NO. 2785

The PRESIDING OFFICER. There will now be 2 minutes of debate equally divided on the amendment offered by the Senator from Oklahoma, Mr. COBURN.

The Senator from Oklahoma is recognized.

Mr. COBURN. This is a straightforward amendment. You get to decide whether you want to continue to send money to an organization that is bankrupt, fraudulent; has peacekeeping troops that rape men, women, and children; has absolutely no transparency in spite of our law that demands it, or to pay for the courage and the support of people who do deserve it.

We always find a reason not to make the hard choice. I suspect we will find a good reason not to make the hard choice this time. But for $3.7 billion to help the people who help us and quit sending money that goes down the tube—half of everything we send to the United Nations gets wasted or defrauded—it is time for us to make the hard choice. That is what the amendment is about. There are a lot of reasons you can find to vote against it. It will take real courage to vote for it.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I urge our colleagues to reject the pending amendment. For one thing, it appears that the amendment could end up denying caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance. While the amendment seeks to ''pay for'' the costs associated with this bill, I understand from CBO, however, that this amendment does not even accomplish what I believe the amendment's author intends.

Every major veterans group supports the underlying bill because of what it means for all veterans—for women veterans, for homeless veterans, and for veterans of every era.

I urge a ''no'' vote on the amendment, followed by a vote to pass S. 1963.

The PRESIDING OFFICER. All time has expired.

The question is on agreeing to the amendment.

Mr. LEMIEUX. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER (Ms. KLOBUCHAR). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 32, nays 66, as follows:

[Rollcall Vote No. 351 Leg.]

YEAS—32

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bayh	Enzi	Murkowski
Bennett	Graham	Risch
Brownback	Hatch	Roberts
Bunning	Hutchison	Sessions
Burr	Inhofe	Shelby
Chambliss	Isakson	Thune
Coburn	Johanns	Vitter
Cornyn	Kyl	Wicker
Crapo	LeMieux	

NAYS—66

Akaka	Gillibrand	Mikulski
Begich	Grassley	Murray
Bennet	Gregg	Nelson (NE)
Bingaman	Hagan	Nelson (FL)
Bond	Harkin	Pryor
Boxer	Inouye	Reed
Brown	Johnson	Reid
Burris	Kaufman	Rockefeller
Cantwell	Kerry	Sanders
Cardin	Kirk	Schumer
Carper	Klobuchar	Shaheen
Casey	Kohl	Snowe
Cochran	Landrieu	Specter
Collins	Lautenberg	Stabenow
Conrad	Leahy	Tester
Corker	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Voinovich
Durbin	Lugar	Warner
Feingold	McCaskill	Webb
Feinstein	Menendez	Whitehouse
Franken	Merkley	Wyden

NOT VOTING—2

Baucus Byrd

The amendment (No. 2785) was rejected.

Mrs. MURRAY. Madam President, I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mrs. MURRAY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on passage of the bill.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 352 Leg.]

YEAS—98

Akaka	Feingold	Menendez
Alexander	Feinstein	Merkley
Barrasso	Franken	Mikulski
Bayh	Gillibrand	Murkowski
Begich	Graham	Murray
Bennet	Grassley	Nelson (NE)
Bennett	Gregg	Nelson (FL)
Bingaman	Hagan	Pryor
Bond	Harkin	Reed
Boxer	Hatch	Reid
Brown	Hutchison	Risch
Brownback	Inhofe	Roberts
Bunning	Inouye	Rockefeller
Burr	Isakson	Sanders
Burris	Johanns	Schumer
Cantwell	Johnson	Sessions
Cardin	Kaufman	Shaheen
Carper	Kerry	Shelby
Casey	Kirk	Snowe
Chambliss	Klobuchar	Specter
Coburn	Kohl	Stabenow
Cochran	Kyl	Tester
Collins	Landrieu	Thune
Conrad	Lautenberg	Udall (CO)
Corker	Leahy	Udall (NM)
Cornyn	LeMieux	Vitter
Crapo	Levin	Voinovich
DeMint	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Lugar	Whitehouse
Durbin	McCain	Wicker
Ensign	McCaskill	Wyden
Enzi	McConnell	

NOT VOTING—2

Baucus Byrd

The bill (S. 1963) was passed, as follows:

S. 1963

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Caregivers and Veterans Omnibus Health Services Act of 2009''.

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

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—CAREGIVER SUPPORT

SEC. 101. WAIVER OF CHARGES FOR HUMANITARIAN CARE PROVIDED TO FAMILY MEMBERS ACCOMPANYING CERTAIN SEVERELY INJURED VETERANS AS THEY RECEIVE MEDICAL CARE.

The text of section 1784 is amended to read as follows:

''(a) IN GENERAL.—The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases.

''(b) REIMBURSEMENT.—Except as provided in subsection (c), the Secretary shall charge for care and services provided under subsection (a) at rates prescribed by the Secretary.

''(c) WAIVER OF CHARGES.—(1) Except as provided in paragraph (2), the Secretary shall waive the charges required by subsection (b) for care or services provided under subsection (a) to an attendant of a covered veteran if such care or services are provided to such attendant for an emergency that occurs while such attendant is accompanying such veteran while such veteran is receiving approved inpatient or outpatient treatment at—

''(A) a Department facility; or

''(B) a non-Department facility—

''(i) that is under contract with the Department; or

''(ii) at which the veteran is receiving fee-basis care.

''(2) If an attendant is entitled to care or services under a health-plan contract (as that term is defined in section 1725(f) of this title) or other contractual or legal recourse against a third party that would, in part, extinguish liability for charges described by subsection (b), the amount of such charges waived under paragraph (1) shall be the amount by which such charges exceed the amount of such charges covered by the health-plan contract or other contractual or legal recourse against the third party.

''(d) DEFINITIONS.—In this section:

''(1) The term 'attendant', with respect to a veteran, includes the following:

''(A) A family member of the veteran.

''(B) An individual eligible to receive ongoing family caregiver assistance under section 1717A(e)(1) of this title for the provision of personal care services to the veteran.

''(C) Any other individual whom the Secretary determines—

''(i) has a relationship with the veteran sufficient to demonstrate a close affinity with the veteran; and

''(ii) provides a significant portion of the veteran's care.

''(2) The term 'covered veteran' means any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001.

''(3) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.

''(4) The term 'severe injury', in the case of a covered veteran, means any physiological, psychological, or neurological condition that renders a veteran unable to live independently as determined by the Secretary.''.

SEC. 102. FAMILY CAREGIVER ASSISTANCE.

(a) REQUIREMENT.—

(1) IN GENERAL.—Subchapter II of chapter 17 is amended by inserting after section 1717 the following new section:

''§ 1717A. Family caregiver assistance

''(a) IN GENERAL.—(1) As part of home health services provided under section 1717 of this title, the Secretary shall, upon the joint application of an eligible veteran and a family member of such veteran (or other individual designated by such veteran), furnish to such family member (or designee) family caregiver assistance in accordance with this section. The purpose of providing family caregiver assistance under this section is—

''(A) to reduce the number of veterans who are receiving institutional care, or who are in need of institutional care, whose personal care service needs could be substantially satisfied with the provision of such services by a family member (or designee); and

''(B) to provide eligible veterans with additional options so that they can choose the setting for the receipt of personal care services that best suits their needs.

''(2) The Secretary shall only furnish family caregiver assistance under this section to a family member of an eligible veteran (or other individual designated by such veteran) if the Secretary determines it is in the best interest of the eligible veteran to do so.

''(b) ELIGIBLE VETERANS.—For purposes of this section, an eligible veteran is a veteran (or member of the Armed Forces undergoing medical discharge from the Armed Forces)—

''(1) who has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and

''(2) whom the Secretary determines, in consultation with the Secretary of Defense as necessary, is in need of personal care services because of—

''(A) an inability to perform one or more independent activities of daily living;

''(B) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or

''(C) such other matters as the Secretary shall establish in consultation with the Secretary of Defense as appropriate.

''(c) EVALUATION OF ELIGIBLE VETERANS AND FAMILY CAREGIVERS.—(1) The Secretary shall evaluate each eligible veteran who makes a joint application under subsection (a)(1)—

''(A) to identify the personal care services required by such veteran; and

''(B) to determine whether such requirements could be significantly or substantially satisfied with the provision of personal care services from a family member (or other individual designated by the veteran).

''(2) The Secretary shall evaluate each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) to determine—

''(A) the basic amount of instruction, preparation, and training such family member (or designee) requires, if any, to provide the personal care services required by such veteran; and

''(B) the amount of additional instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under subsection (e).

''(3) An evaluation carried out under paragraph (1) may be carried out—

''(A) at a Department facility;

''(B) at a non-Department facility determined appropriate by the Secretary for purposes of such evaluation; and

''(C) at such other locations as the Secretary considers appropriate.

''(d) TRAINING AND APPROVAL.—(1) Except as provided in subsection (a)(2), the Secretary shall provide each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) the basic instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(A).

''(2) The Secretary may provide to a family member of an eligible veteran (or other individual designated by the veteran) the additional instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(B) if such family member (or designee)—

''(A) is approved as a personal care attendant for the veteran under paragraph (3); and

''(B) requests, with concurrence of the veteran, such additional instruction, preparation, and training.

''(3) Upon the successful completion by a family member of an eligible veteran (or other individual designated by the veteran)

of basic instruction, preparation, and training provided under paragraph (1), the Secretary shall approve the family member as a personal care attendant for the veteran.

''(4) If the Secretary determines that a primary personal care attendant designated under subsection (e) requires additional training to maintain such designation, the Secretary shall make such training available to the primary personal care attendant.

''(5) The Secretary shall, subject to regulations the Secretary shall prescribe, provide for necessary travel, lodging, and per diem expenses incurred by a family member of an eligible veteran (or other individual designated by the veteran) in undergoing training under this subsection.

''(6) If the participation of a family member of an eligible veteran (or other individual designated by the veteran) in training under this subsection would interfere with the provision of personal care services to the veteran, the Secretary shall, subject to regulations as the Secretary shall prescribe and in consultation with the veteran, provide respite care to the veteran during the provision of such training to the family member so that such family caregiver (or designee) can participate in such training without interfering with the provision of such services.

''(e) DESIGNATION OF PRIMARY PERSONAL CARE ATTENDANT.—(1) For each eligible veteran with at least one family member (or other individual designated by the veteran) who is described by subparagraphs (A) through (E) of paragraph (2), the Secretary shall designate one family member of such veteran (or other individual designated by the veteran) as the primary personal care attendant for such veteran to be the primary provider of personal care services for such veteran.

''(2) A primary personal care attendant designated for an eligible veteran under paragraph (1) shall be selected from among family members of such veteran (or other individuals designated by such veteran) who—

''(A) are approved under subsection (d)(3) as a personal care attendant for such veteran;

''(B) complete all additional instruction, preparation, and training, if any, provided under subsection (d)(2);

''(C) elect to provide the personal care services to such veteran that the Secretary determines such veteran requires under subsection (c)(1);

''(D) has the consent of such veteran to be the primary provider of such services for such veteran; and

''(E) the Secretary considers competent to be the primary provider of such services for such veteran.

''(3)(A) An eligible veteran receiving personal care services from a family member (or other individual designated by the veteran) designated as the primary personal care attendant for the veteran under paragraph (1) may revoke consent with respect to such family member (or designee) under paragraph (2)(D).

''(B) An eligible veteran may revoke the designation of a primary personal care attendant under subparagraph (A) at any time, except that such revocation may not occur more frequently than once every six months unless the Secretary determines it is in the best interest of the eligible veteran to permit such revocation to occur more frequently.

''(4) If an individual designated as the primary personal care attendant of an eligible veteran under paragraph (1) subsequently fails to meet the requirements set forth in paragraph (2), the Secretary—

''(A) shall immediately revoke the individual's designation under paragraph (1); and

''(B) may designate, in consultation with the eligible veteran or the eligible veteran's surrogate appointed under subsection (g), a new primary personal care attendant for the veteran under such paragraph.

''(5) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under paragraph (1) does not interfere with the provision of personal care services required by a veteran.

''(f) ONGOING FAMILY CAREGIVER ASSISTANCE.—(1) Except as provided in subsection (a)(2) and subject to the provisions of this subsection, the Secretary shall provide ongoing family caregiver assistance to family members of eligible veterans (or other individuals designated by such veterans) as follows:

''(A) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran the following:

''(i) Direct technical support consisting of information and assistance to timely address routine, emergency, and specialized caregiving needs.

''(ii) Counseling.

''(iii) Access to an interactive Internet website on caregiver services that addresses all aspects of the provision of personal care services under this section.

''(B) To each family member of an eligible veteran (or designee) who is designated as the primary personal care attendant for the veteran under subsection (e) the following:

''(i) The ongoing family caregiver assistance described in subparagraph (A).

''(ii) Mental health services.

''(iii) Respite care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite.

''(iv) Medical care under section 1781 of this title if such family member (or designee) is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title).

''(v) A monthly personal caregiver stipend.

''(2)(A) The Secretary shall provide respite care under paragraph (1)(B)(iii), at the election of the Secretary—

''(i) through facilities of the Department that are appropriate for the veteran; or

''(ii) through contracts under section 1720B(c) of this title.

''(B) If the primary personal care attendant of an eligible veteran designated under subsection (e)(1) determines in consultation with the veteran or the veteran's surrogate appointed under subsection (g), and the Secretary concurs, that the needs of the veteran cannot be accommodated through the facilities and contracts described in subparagraph (A), the Secretary shall, in consultation with the primary personal care attendant and the veteran (or the veteran's surrogate), provide respite care through other facilities or arrangements that are medically and age appropriate.

''(3) If the Secretary determines that the Department lacks the capacity to furnish medical care under clause (iv) of paragraph (1)(B), the Secretary may contract, in accordance with such regulations as the Secretary shall prescribe, for such insurance, medical services, or health plans as the Secretary considers appropriate to furnish such medical care.

''(4)(A) The Secretary shall provide monthly personal caregiver stipends under paragraph (1)(B)(v) in accordance with a schedule established by the Secretary that specifies stipends provided based upon the amount and degree of personal care services provided.

''(B) The Secretary shall ensure, to the extent practicable, that the schedule required by subparagraph (A) specifies that the amount of the personal caregiver stipend provided to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount a commercial home health care entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

''(C) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary may establish the schedule required by subparagraph (A) with respect to the veteran by considering the costs of commercial providers of personal care services in geographic areas other than the geographic area of the veteran with similar costs of living.

''(5) Provision of ongoing family caregiver assistance under this subsection for provision of personal care services to an eligible veteran shall terminate if the veteran no longer requires the personal care services.

''(g) SURROGATES.—If an eligible veteran lacks the capacity to submit an application, provide consent, make a request, or concur with a request under this section, the Secretary may, in accordance with regulations and policies of the Department regarding the appointment of guardians or the use of powers of attorney, appoint a surrogate for the veteran who may submit applications, provide consent, make requests, or concur with requests on behalf of the veteran under this section.

''(h) OVERSIGHT.—(1) The Secretary shall enter into contracts with appropriate entities to provide oversight of the provision of personal care services under this section by primary personal care attendants designated under subsection (e)(1).

''(2) The Secretary shall ensure that each eligible veteran receiving personal care services under this section from a primary personal care attendant designated under subsection (e)(1) is visited in the veteran's home by an entity providing oversight under paragraph (1) at such frequency as the Secretary shall determine under paragraph (3).

''(3)(A) Except as provided in subparagraph (B), the Secretary shall determine the manner of oversight provided under paragraph (1) and the frequency of visits under paragraph (2) for an eligible veteran as the Secretary considers commensurate with the needs of such veteran.

''(B) The frequency of visits under paragraph (2) for an eligible veteran shall be not less frequent than once every six months.

''(4)(A) An entity visiting an eligible veteran under paragraph (2) shall submit to the Secretary the findings of the entity with respect to each visit, including whether the veteran is receiving the care the veteran requires.

''(B) If an entity finds under subparagraph (A) that an eligible veteran is not receiving the care the veteran requires, the entity shall submit to the Secretary a recommendation on the corrective actions that should be taken to ensure that the veteran receives the care the veteran requires, including, if the entity considers appropriate, a recommendation for revocation of a caregiver's approval under subsection (d)(3) or revocation of the designation of an individual under subsection (e)(1).

''(5) After receiving findings and recommendations, if any, under paragraph (4) with respect to an eligible veteran, the Secretary may take such actions as the Secretary considers appropriate to ensure that the veteran receives the care the veteran requires, including the following:

''(A) Revocation of a caregiver's approval under subsection (d)(3).

''(B) Revocation of the designation of an individual under subsection (e)(1).

''(6) If the Secretary terminates the provision of ongoing family caregiver assistance

under subsection (f) to a family member of an eligible veteran (or other individual designated by the veteran) because of findings of an entity submitted to the Secretary under paragraph (4), the Secretary may not provide compensation to such entity for the provision of personal care services to such veteran, unless the Secretary determines it would be in the best interest of such veteran to provide compensation to such entity to provide such services.

''(i) OUTREACH.—The Secretary shall carry out a program of outreach to inform eligible veterans and their family members of the availability and nature of family caregiver assistance under this section.

''(j) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of family caregiver assistance shall be considered a medical determination.

''(2) Nothing in this section shall be construed to create an employment relationship between the Secretary and an individual in receipt of family caregiver assistance under this section.

''(3) Nothing in this section shall be construed to create any entitlement to any services or stipends provided under this section.

''(k) DEFINITIONS.—In this section:

''(1) The term 'family caregiver assistance' includes the instruction, preparation, training, and approval provided under subsection (d) and the ongoing family caregiver assistance provided under subsection (f).

''(2) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.

''(3) The term 'personal care services', with respect to a veteran, includes the following:

''(A) Supervision of the veteran.

''(B) Protection of the veteran.

''(C) Services to assist the veteran with one or more independent activities of daily living.

''(D) Such other services as the Secretary considers appropriate.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1717 the following new item:

''1717A. Family caregiver assistance.''.

(3) AUTHORIZATION FOR PROVISION OF HEALTH CARE TO PERSONAL CARE ATTENDANTS.—Section 1781(a) is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following new paragraph (2):

''(2) a family member of a veteran (or other individual designated by the veteran) designated as the primary personal care attendant for such veteran under section 1717A(e) of this title who is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title),''.

(4) CONSTRUCTION.—Any family caregiver assistance furnished under section 1717A of title 38, United States Code, as added by paragraph (1), is in addition to any family caregiver assistance furnished under other programs of the Department of Veterans Affairs as of the date of the enactment of this Act.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(b) IMPLEMENTATION PLAN AND REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) develop a plan for the implementation of section 1717A of title 38, United States Code, as added by subsection (a)(1); and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on such plan.

(2) CONSULTATION.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Veterans described in section 1717A(b) of title 38, United States Code, as added by subsection (a)(1).

(B) Family members of veterans who provide personal care services to such veterans.

(C) Veterans service organizations, as recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(D) National organizations that specialize in the provision of assistance to individuals with the types of disabilities that personal care attendants will encounter while providing personal care services under section 1717A of title 38, United States Code, as so added.

(E) Such other organizations with an interest in the provision of care to veterans as the Secretary considers appropriate.

(F) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from family caregiver assistance furnished under section 1717A of title 38, United States Code, as so added.

(3) REPORT CONTENTS.—The report required by paragraph (1)(B) shall contain the following:

(A) The plan required by paragraph (1)(A).

(B) A description of the veterans, caregivers, and organizations consulted by the Secretary under paragraph (2).

(C) A description of such consultations.

(D) The recommendations of such veterans, caregivers, and organizations, if any, that were not incorporated into the plan required by paragraph (1)(A).

(E) The reasons the Secretary did not incorporate such recommendations into such plan.

(c) ANNUAL EVALUATION REPORT.—

(1) IN GENERAL.—Not later than two years after the date described in subsection (a)(5) and annually thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a comprehensive report on the implementation of section 1717A of title 38, United States Code, as added by subsection (a)(1).

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) The number of family members (or other designated individuals) of veterans or members of the Armed Forces that received family caregiver assistance under such section 1717A.

(B) A description of the outreach activities carried out by the Secretary in accordance with subsection (i) of such section 1717A.

(C) The resources expended by the Secretary under such section 1717A.

(D) An assessment of the manner in which resources are expended by the Secretary under such section 1717A, particularly with respect to the provision of monthly personal caregiver stipends under subsection (f) of such section.

(E) A description of the outcomes achieved by, and any measurable benefits of, carrying out the requirements of such section 1717A.

(F) A justification of any determination made under subsection (b)(2) of such section 1717A.

(G) An assessment of the effectiveness and the efficiency of the implementation of such section 1717A.

(H) An assessment of how the provision of family caregiver assistance fits into the continuum of home health care services and benefits provided to veterans in need of such services and benefits.

(I) Such recommendations, including recommendations for legislative or administrative action, as the Secretary considers appropriate in light of carrying out the requirements of such section 1717A.

(d) REPORT ON FEASIBILITY AND ADVISABILITY OF EXPANDING CAREGIVER ASSISTANCE.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of expanding the provision of family caregiver assistance under section 1717A of title 38, United States Code, as added by subsection (a)(1), to family members of veterans (or other individuals designated by such veterans) who—

(A) have a serious injury described in subsection (b)(1) of such section 1717A incurred or aggravated before September 11, 2001; and

(B) are described in paragraph (2) of such subsection.

(2) RECOMMENDATIONS.—The report required by paragraph (1) shall include such recommendations as the Secretary considers appropriate with respect to the expansion described in such paragraph.

SEC. 103. LODGING AND SUBSISTENCE FOR ATTENDANTS.

Section 111(e) is amended—

(1) by striking ''When any'' and inserting ''(1) When any'';

(2) in paragraph (1), as designated by paragraph (1) of this subsection—

(A) by inserting ''(including lodging and subsistence)'' after ''expenses of travel''; and

(B) by inserting before the period at the end the following: ''for the period consisting of travel to and from a treatment facility and the duration of the treatment episode at that facility''; and

(3) by adding at the end the following:

''(2) The Secretary may prescribe regulations to carry out this subsection. Such regulations may include provisions—

''(A) to limit the number of individuals that may receive expenses of travel under paragraph (1) for a single treatment episode of a person; and

''(B) to require attendants to use certain travel services.

''(3) In this subsection:

''(A) The term 'attendant' includes, with respect to a person described in paragraph (1), the following:

''(i) A family member of the person.

''(ii) An individual approved as a personal care attendant under section 1717A(d)(3) of this title.

''(iii) Any other individual whom the Secretary determines—

''(I) has a preexisting relationship with the person; and

''(II) provides a significant portion of the person's care.

''(B) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.''.

SEC. 104. SURVEY OF INFORMAL CAREGIVERS.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, conduct a national survey of family caregivers of seriously disabled veterans and members of the Armed Forces to better understand the size and characteristics of the population of such caregivers and the types of care they provide such veterans and members.

(b) REPORT.—Not later than 540 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense,

submit to Congress a report containing the findings of the Secretary with respect to the survey conducted under subsection (a). Results of the survey shall be disaggregated by the following:

(1) Veterans and members of the Armed Forces.

(2) Veterans and members of the Armed Forces who served in Operation Iraqi Freedom or Operation Enduring Freedom.

(3) Veterans and members of the Armed Forces who live in rural areas.

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS

SEC. 201. REPORT ON BARRIERS TO RECEIPT OF HEALTH CARE FOR WOMEN VETERANS.

(a) REPORT.—Not later than June 1, 2010, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the barriers to the receipt of comprehensive health care through the Department of Veterans Affairs that are encountered by women veterans, especially veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) An identification and assessment of the following:

(A) Any stigma perceived or associated with seeking mental health care services through the Department of Veterans Affairs.

(B) The effect on access to care through the Department of driving distance or availability of other forms of transportation to the nearest appropriate facility of the Department.

(C) The availability of child care.

(D) The receipt of health care through women's health clinics, integrated primary care clinics, or both.

(E) The extent of comprehension of eligibility requirements for health care through the Department, and the scope of health care services available through the Department.

(F) The quality and nature of the reception of women veterans by Department health care providers and other staff.

(G) The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.

(H) The sensitivity of Department health care providers and other staff to issues that particularly affect women.

(I) The effectiveness of outreach on health care services of the Department that are available to women veterans.

(J) Such other matters as the Secretary identifies for purposes of the assessment.

(2) Such recommendations for administrative and legislative action as the Secretary considers appropriate in light of the report.

(c) FACILITY OF THE DEPARTMENT DEFINED.—In this section, the term ''facility of the Department'' has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. PLAN TO IMPROVE PROVISION OF HEALTH CARE SERVICES TO WOMEN VETERANS.

(a) PLAN TO IMPROVE SERVICES.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall develop a plan—

(A) to improve the provision of health care services to women veterans; and

(B) to plan appropriately for the future health care needs, including mental health care needs, of women serving on active duty in the Armed Forces in the combat theaters of Operation Iraqi Freedom and Operation Enduring Freedom.

(2) REQUIRED ACTIONS.—In developing the plan required by this subsection, the Secretary of Veterans Affairs shall—

(A) identify the types of health care services to be available to women veterans at each Department of Veterans Affairs medical center; and

(B) identify the personnel and other resources required to provide such services to women veterans under the plan at each such medical center.

(b) SUBMITTAL OF PLAN TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives the plan required by this section, along with such recommendations for administrative and legislative action as the Secretary considers appropriate in light of the plan.

SEC. 203. INDEPENDENT STUDY ON HEALTH CONSEQUENCES OF WOMEN VETERANS OF MILITARY SERVICE IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall enter into an agreement with a non-Department of Veterans Affairs entity for the purpose of conducting a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

(b) SPECIFIC MATTERS STUDIED.—The study under subsection (a) shall include the following:

(1) A determination of any association of environmental and occupational exposures and combat in Operation Iraqi Freedom or Operation Enduring Freedom with the general health, mental health, or reproductive health of women who served on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom.

(2) A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(c) REPORT.—

(1) IN GENERAL.—Not later than 18 months after entering into the agreement for the study under subsection (a), the entity described in subsection (a) shall submit to the Secretary of Veterans Affairs and to Congress a report on the study containing such findings and determinations as the entity considers appropriate.

(2) RESPONSIVE REPORT.—Not later than 90 days after the receipt of the report under paragraph (1), the Secretary shall submit to Congress a report setting forth the response of the Secretary to the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

SEC. 204. TRAINING AND CERTIFICATION FOR MENTAL HEALTH CARE PROVIDERS ON CARE FOR VETERANS SUFFERING FROM SEXUAL TRAUMA.

(a) PROGRAM REQUIRED.—Section 1720D is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

''(d)(1) The Secretary shall implement a program for education, training, certification, and continuing medical education for mental health professionals to specialize in the provision of counseling and care to veterans eligible for services under subsection (a). In carrying out the program, the Secretary shall ensure that all such mental health professionals have been trained in a consistent manner and that such training includes principles of evidence-based treatment and care for sexual trauma.

''(2) The Secretary shall determine the minimum qualifications necessary for mental health professionals certified by the program under paragraph (1) to provide evidence-based treatment and therapy to veterans eligible for services under subsection (a) in facilities of the Department.

''(e) The Secretary shall submit to Congress each year a report on the counseling, care, and services provided to veterans under this section. Each report shall include data for the preceding year with respect to the following:

''(1) The number of mental health professionals and primary care providers who have been certified under the program under subsection (d), and the amount and nature of continuing medical education provided under such program to professionals and providers who have been so certified.

''(2) The number of women veterans who received counseling, care, and services under subsection (a) from professionals and providers who have been trained or certified under the program under subsection (d).

''(3) The number of training, certification, and continuing medical education programs operating under subsection (d).

''(4) The number of trained full-time equivalent employees required in each facility of the Department to meet the needs of veterans requiring treatment and care for sexual trauma.

''(5) Such other information as the Secretary considers appropriate.''.

(b) STANDARDS FOR PERSONNEL PROVIDING TREATMENT FOR SEXUAL TRAUMA.—The Secretary of Veterans Affairs shall establish education, training, certification, and staffing standards for Department of Veterans Affairs health-care facilities for full-time equivalent employees who are trained to provide treatment and care to veterans for sexual trauma.

SEC. 205. PILOT PROGRAM ON COUNSELING IN RETREAT SETTINGS FOR WOMEN VETERANS NEWLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) PILOT PROGRAM REQUIRED.—

(1) IN GENERAL.—Commencing not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall carry out, through the Readjustment Counseling Service of the Veterans Health Administration, a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services described in subsection (b) in group retreat settings to women veterans who are recently separated from service in the Armed Forces after a prolonged deployment.

(2) PARTICIPATION AT ELECTION OF VETERAN.—The participation of a veteran in the pilot program under this section shall be at the election of the veteran.

(b) COVERED SERVICES.—The services provided to a woman veteran under the pilot program shall include the following:

(1) Information on reintegration into the veteran's family, employment, and community.

(2) Financial counseling.

(3) Occupational counseling.

(4) Information and counseling on stress reduction.

(5) Information and counseling on conflict resolution.

(6) Such other information and counseling as the Secretary considers appropriate to assist a woman veteran under the pilot program in reintegration into the veteran's family and community.

(c) LOCATIONS.—The Secretary shall carry out the pilot program at not fewer than five locations selected by the Secretary for purposes of the pilot program.

(d) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(e) REPORT.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall contain the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $2,000,000 to carry out the pilot program.

SEC. 206. REPORT ON FULL-TIME WOMEN VETERANS PROGRAM MANAGERS AT MEDICAL CENTERS.

The Secretary shall, acting through the Under Secretary for Health, submit to Congress a report on employment of full-time women veterans program managers at Department of Veterans Affairs medical centers to ensure that health care needs of women veterans are met. Such report should include an assessment of whether there is at least one full-time employee at each Department medical center who is a full-time women veterans program manager.

SEC. 207. SERVICE ON CERTAIN ADVISORY COMMITTEES OF WOMEN RECENTLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) ADVISORY COMMITTEE ON WOMEN VETERANS.—Section 542(a)(2)(A) is amended—

(1) in clause (ii), by striking ''and'' at the end;

(2) in clause (iii), by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (iii) the following new clause:

''(iv) women veterans who are recently separated from service in the Armed Forces.''.

(b) ADVISORY COMMITTEE ON MINORITY VETERANS.—Section 544(a)(2)(A) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv), by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (iv) the following new clause:

''(v) women veterans who are minority group members and are recently separated from service in the Armed Forces.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appointments made on or after the date of the enactment of this Act.

SEC. 208. PILOT PROGRAM ON SUBSIDIES FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing, subject to subsection (b), subsidies to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in such subsection.

(b) LIMITATION ON PERIOD OF PAYMENTS.—A subsidy may only be provided to a qualified veteran under the pilot program for receipt of child care during the period that the qualified veteran—

(1) receives the types of health care services referred to in subsection (c) at a facility of the Department; and

(2) requires to travel to and return from such facility for the receipt of such health care services.

(c) QUALIFIED VETERANS.—In this section, the term ''qualified veteran'' means a veteran who is the primary caretaker of a child or children and who is receiving from the Department one or more of the following health care services:

(1) Regular mental health care services.

(2) Intensive mental health care services.

(3) Such other intensive health care services that the Secretary determines that payment to the veteran for the provision of child care would improve access to those health care services by the veteran.

(d) LOCATIONS.—The Secretary shall carry out the pilot program in no fewer than three Veterans Integrated Service Networks (VISNs) selected by the Secretary for purposes of the pilot program.

(e) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(f) EXISTING MODEL.—To the extent practicable, the Secretary shall model the pilot program after the Department of Veterans Affairs Child Care Subsidy Program that was established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552), using the same income eligibility standards and payment structure.

(g) REPORT.—Not later than six months after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $1,500,000 to carry out the pilot program.

SEC. 209. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE.

(a) IN GENERAL.—Subchapter VIII of chapter 17 is amended by adding at the end the following new section:

''SEC. 1786. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE.

''(a) IN GENERAL.—The Secretary may furnish health care services described in subsection (b) to a newborn child of a woman veteran who is receiving maternity care furnished by the Department for not more than 7 days after the birth of the child if the veteran delivered the child in—

''(1) a facility of the Department; or

''(2) another facility pursuant to a Department contract for services relating to such delivery.

''(b) COVERED HEALTH CARE SERVICES.—Health care services described in this subsection are all post-delivery care services, including routine care services, that a newborn requires.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1785 the following new item:

''1786. Care for newborn children of women veterans receiving maternity care.''.

TITLE III—RURAL HEALTH IMPROVEMENTS

SEC. 301. ENHANCEMENT OF DEPARTMENT OF VETERANS AFFAIRS EDUCATION DEBT REDUCTION PROGRAM.

(a) ENHANCED MAXIMUM ANNUAL AMOUNT.—Paragraph (1) of section 7683(d) is amended by striking ''$44,000'' and all that follows through ''fifth years of participation in the Program'' and inserting ''the total amount of principle and interest owed by the participant on loans referred to in subsection (a)''.

(b) NOTICE TO POTENTIAL EMPLOYEES OF ELIGIBILITY AND SELECTION FOR PARTICIPATION.—Section 7682 is amended by adding at the end the following new subsection:

''(d) NOTICE TO POTENTIAL EMPLOYEES.—In each offer of employment made by the Secretary to an individual who, upon acceptance of such offer would be treated as eligible to participate in the Education Debt Reduction Program, the Secretary shall, to the maximum extent practicable, include the following:

''(1) A notice that the individual will be treated as eligible to participate in the Education Debt Reduction Program upon the individual's acceptance of such offer.

''(2) A notice of the determination of the Secretary whether or not the individual will be selected as a participant in the Education Debt Reduction Program as of the individual's acceptance of such offer.''.

(c) SELECTION OF EMPLOYEES WHO RECEIVE NOTICE OF SELECTION WITH EMPLOYMENT OFFER.—Section 7683 is further amended by adding at the end the following new subsection:

''(e) SELECTION OF PARTICIPANTS.—(1) The Secretary shall select for participation in the Education Debt Reduction Program each individual eligible for participation in the Education Debt Reduction Program who—

''(A) the Secretary provided notice with an offer of employment under section 7682(d) of this title that indicated the individual would, upon the individual's acceptance of such offer of employment, be—

''(i) eligible to participate in the Education Debt Reduction Program; and

''(ii) selected to participate in the Education Debt Reduction Program; and

''(B) accepts such offer of employment.

''(2) The Secretary may select for participation in the Education Debt Reduction Program an individual eligible for participation in the Education Debt Reduction Program who is not described by subparagraphs (A) and (B) of paragraph (1).''.

SEC. 302. VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONALS EDUCATION ASSISTANCE PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Part V is amended by inserting after chapter 74 the following new chapter:

''CHAPTER 75—VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONALS EDUCATION ASSISTANCE PROGRAM

''§ 7501. Establishment of scholarship program; purpose

''(a) ESTABLISHMENT.—Subject to the availability of appropriations, the Secretary shall establish and carry out a scholarship program to provide financial assistance in accordance with this chapter to an individual—

''(1) who is accepted for enrollment or currently enrolled in a program of study leading to a degree or certificate in visual impairment or orientation and mobility, or a dual degree or certification in both such areas, at an accredited (as determined by the Secretary) educational institution that is in a State; and

''(2) who enters into an agreement with the Secretary as described in section 7504 of this chapter.

''(b) PURPOSE.—The purpose of the scholarship program established under this chapter is to increase the supply of qualified blind rehabilitation specialists for the Department and the Nation.

''(c) OUTREACH.—The Secretary shall publicize the scholarship program established

under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to such institutions with high numbers of Hispanic students and to Historically Black Colleges and Universities.

''§ 7502. Application and acceptance

''(a) APPLICATION.—(1) To apply and participate in the scholarship program under this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7504 of this chapter under which the participant agrees to serve a period of obligated service in the Department as provided in the agreement in return for payment of educational assistance as provided in the agreement.

''(2) In distributing application forms and agreement forms to individuals desiring to participate in the scholarship program, the Secretary shall include with such forms the following:

''(A) A fair summary of the rights and liabilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary.

''(B) A full description of the terms and conditions that apply to participation in the scholarship program and service in the Department.

''(b) APPROVAL.—(1) Upon the Secretary's approval of an individual's participation in the scholarship program, the Secretary shall, in writing, promptly notify the individual of that acceptance.

''(2) An individual becomes a participant in the scholarship program upon such approval by the Secretary.

''§ 7503. Amount of assistance; duration

''(a) AMOUNT OF ASSISTANCE.—The amount of the financial assistance provided for an individual under this chapter shall be the amount determined by the Secretary as being necessary to pay the tuition and fees of the individual. In the case of an individual enrolled in a program of study leading to a dual degree or certification in both the areas of study described in section 7501(a)(1) of this chapter, the tuition and fees shall not exceed the amounts necessary for the minimum number of credit hours to achieve such dual certification or degree.

''(b) RELATIONSHIP TO OTHER ASSISTANCE.—Financial assistance may be provided to an individual under this chapter to supplement other educational assistance to the extent that the total amount of educational assistance received by the individual during an academic year does not exceed the total tuition and fees for such academic year.

''(c) MAXIMUM AMOUNT OF ASSISTANCE.—(1) In no case may the total amount of assistance provided under this chapter for an academic year to an individual who is a full-time student exceed $15,000.

''(2) In the case of an individual who is a part-time student, the total amount of assistance provided under this chapter shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the program of study being pursued by the individual as the coursework carried by the individual to full-time coursework in that program of study.

''(3) In no case may the total amount of assistance provided to an individual under this chapter exceed $45,000.

''(d) MAXIMUM DURATION OF ASSISTANCE.—The Secretary may provide financial assistance to an individual under this chapter for not more than six years.

''§ 7504. Agreement

''An agreement between the Secretary and a participant in the scholarship program under this chapter shall be in writing, shall be signed by the participant, and shall include—

''(1) the Secretary's agreement to provide the participant with financial assistance as authorized under this chapter;

''(2) the participant's agreement—

''(A) to accept such financial assistance;

''(B) to maintain enrollment and attendance in the program of study described in section 7501(a)(1) of this chapter;

''(C) while enrolled in such program, to maintain an acceptable level of academic standing (as determined by the educational institution offering such program under regulations prescribed by the Secretary); and

''(D) after completion of the program, to serve as a full-time employee in the Department for a period of three years, to be served within the first six years after the participant has completed such program and received a degree or certificate described in section 7501(a)(1) of this chapter; and

''(3) any other terms and conditions that the Secretary determines appropriate for carrying out this chapter.

''§ 7505. Repayment for failure to satisfy requirements of agreement

''(a) IN GENERAL.—An individual who receives educational assistance under this chapter shall repay to the Secretary an amount equal to the unearned portion of such assistance if the individual fails to satisfy the requirements of the agreement entered into under section 7504 of this chapter, except in circumstances authorized by the Secretary.

''(b) AMOUNT OF REPAYMENT.—The Secretary shall establish, by regulations, procedures for determining the amount of the repayment required under this subsection and the circumstances under which an exception to the required repayment may be granted.

''(c) WAIVER OR SUSPENSION OF COMPLIANCE.—The Secretary shall prescribe regulations providing for the waiver or suspension of any obligation of an individual for service or payment under this chapter (or an agreement under this chapter) whenever noncompliance by the individual is due to circumstances beyond the control of the individual or whenever the Secretary determines that the waiver or suspension of compliance is in the best interest of the United States.

''(d) OBLIGATION AS DEBT TO UNITED STATES.—An obligation to repay the Secretary under this section is, for all purposes, a debt owed the United States. A discharge in bankruptcy under title 11 does not discharge a person from such debt if the discharge order is entered less than five years after the date of the termination of the agreement or contract on which the debt is based.''.

(b) CLERICAL AMENDMENTS.—The tables of chapters at the beginning of title 38, and of part V of title 38, are each amended by inserting after the item relating to chapter 74 the following new item:

''75. Visual Impairment and Orientation and Mobility Professionals Education Assistance Program ... 7501.''.

(c) EFFECTIVE DATE.—The Secretary of Veterans Affairs shall implement chapter 75 of title 38, United States Code, as added by subsection (a), not later than six months after the date of the enactment of this Act.

SEC. 303. INCLUSION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES IN LIST OF FACILITIES ELIGIBLE FOR ASSIGNMENT OF PARTICIPANTS IN NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.

The Secretary of Veterans Affairs shall transfer $20,000,000 from accounts of the Veterans Health Administration to the Secretary of Health and Human Services to include facilities of the Department of Veterans Affairs in the list maintained by the Health Resources and Services Administration of facilities eligible for assignment of participants in the National Health Service Corps Scholarship Program.

SEC. 304. TELECONSULTATION AND TELEMEDICINE.

(a) TELECONSULTATION AND TELERETINAL IMAGING.—

(1) IN GENERAL.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

''§ 1709. Teleconsultation and teleretinal imaging

''(a) TELECONSULTATION.—(1) The Secretary shall carry out a program of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that are not otherwise able to provide such assessments without contracting with third party providers or reimbursing providers through a fee-basis system.

''(2) The Secretary shall, in consultation with appropriate professional societies, promulgate technical and clinical care standards for the use of teleconsultation services within facilities of the Department.

''(b) TELERETINAL IMAGING.—The Secretary shall carry out a program of teleretinal imaging in each Veterans Integrated Services Network (VISN).

''(c) ANNUAL REPORTS.—In each fiscal year beginning with fiscal year 2010 and ending with fiscal year 2015, the Secretary shall submit to Congress a report on the programs required by subsections (a) and (b). Such report shall include the following:

''(1) A description of the efforts made by the Secretary to make teleconsultation available in rural areas and to utilize teleconsultation in rural areas.

''(2) The rates of utilization of teleconsultation by Veterans Integrated Services Network disaggregated by each fiscal year for which a report is submitted under this subsection.

''(d) DEFINITIONS.—In this section:

''(1) The term 'teleconsultation' means the use by a health care specialist of telecommunications to assist another health care provider in rendering a diagnosis or treatment.

''(2) The term 'teleretinal imaging' means the use by a health care specialist of telecommunications, digital retinal imaging, and remote image interpretation to provide eye care.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1708 the following new item:

''1709. Teleconsultation and teleretinal imaging.''.

(b) TRAINING IN TELEMEDICINE.—The Secretary of Veterans Affairs shall require each Department of Veterans Affairs facility that is involved in the training of medical residents to work with each university concerned to develop an elective rotation in telemedicine for such residents.

(c) ENHANCEMENT OF VERA.—

(1) INCENTIVES FOR PROVISION OF TELECONSULTATION, TELERETINAL IMAGING, TELEMEDICINE, AND TELEHEALTH SERVICES.—The Secretary of Veterans Affairs shall modify the Veterans Equitable Resource Allocation system to provide Veterans Integrated Services Networks with incentives to utilize teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services.

(2) INCLUSION OF TELEMEDICINE VISITS IN WORKLOAD REPORTING.—The Secretary shall modify the Veterans Equitable Resource Allocation system to require the inclusion of all telemedicine visits in the calculation of facility workload.

(d) DEFINITIONS.—In this section:

(1) The terms ''teleconsultation'' and ''teleretinal imaging'' have the meanings given such terms in section 1709 of title 38, United States Code, as added by subsection (a).

(2) The term ''telemedicine'' means the use by a health care provider of telecommunications to assist in the diagnosis or treatment of a patient's medical condition.

(3) The term ''telehealth'' means the use of telecommunications to collect patient data remotely and send data to a monitoring station for interpretation.

SEC. 305. DEMONSTRATION PROJECTS ON ALTERNATIVES FOR EXPANDING CARE FOR VETERANS IN RURAL AREAS.

(a) IN GENERAL.—The Secretary of Veterans Affairs, through the Director of the Office of Rural Health, may carry out demonstration projects to examine the feasibility and advisability of alternatives for expanding care for veterans in rural areas, which may include the following:

(1) Establishing a partnership between the Department of Veterans Affairs and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services to coordinate care for veterans in rural areas at critical access hospitals (as designated or certified under section 1820 of the Social Security Act (42 U.S.C. 1395i–4)).

(2) Establishing a partnership between the Department of Veterans Affairs and the Department of Health and Human Services to coordinate care for veterans in rural areas at community health centers.

(3) Expanding coordination between the Department of Veterans Affairs and the Indian Health Service to expand care for Indian veterans.

(b) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that the demonstration projects carried out under subsection (a) are located at facilities that are geographically distributed throughout the United States.

(c) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary shall submit a report on the results of the demonstration projects conducted under subsection (a) to—

(1) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(2) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2010 and each fiscal year thereafter.

SEC. 306. PROGRAM ON PROVISION OF READJUSTMENT AND MENTAL HEALTH CARE SERVICES TO VETERANS WHO SERVED IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) PROGRAM REQUIRED.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish a program to provide—

(1) to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, particularly veterans who served in such operations while in the National Guard and the Reserves—

(A) peer outreach services;

(B) peer support services;

(C) readjustment counseling and services described in section 1712A of title 38, United States Code; and

(D) mental health services; and

(2) to members of the immediate family of such a veteran, during the three-year period beginning on the date of the return of such veteran from deployment in Operation Iraqi Freedom or Operation Enduring Freedom, education, support, counseling, and mental health services to assist in—

(A) the readjustment of such veteran to civilian life;

(B) in the case such veteran has an injury or illness incurred during such deployment, the recovery of such veteran; and

(C) the readjustment of the family following the return of such veteran.

(b) CONTRACTS WITH COMMUNITY MENTAL HEALTH CENTERS AND QUALIFIED ENTITIES FOR PROVISION OF SERVICES.—In carrying out the program required by subsection (a), the Secretary shall contract with community mental health centers and other qualified entities to provide the services required by such subsection only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. Such contracts shall require each contracting community health center or entity—

(1) to the extent practicable, to use telehealth services for the delivery of services required by subsection (a);

(2) to the extent practicable, to employ veterans trained under subsection (c);

(3) to participate in the training program conducted in accordance with subsection (d);

(4) to comply with applicable protocols of the Department before incurring any liability on behalf of the Department for the provision of the services required by subsection (a);

(5) for each veteran for whom a community mental health center or other qualified entity provides mental health services under such contract, to provide the Department with such clinical summary information as the Secretary shall require;

(6) to submit annual reports to the Secretary containing, with respect to the program required by subsection (a) and for the last full calendar year ending before the submission of such report—

(A) the number of the veterans served, veterans diagnosed, and courses of treatment provided to veterans as part of the program required by subsection (a); and

(B) demographic information for such services, diagnoses, and courses of treatment; and

(7) to meet such other requirements as the Secretary shall require.

(c) TRAINING OF VETERANS FOR THE PROVISION OF PEER-OUTREACH AND PEER-SUPPORT SERVICES.—In carrying out the program required by subsection (a), the Secretary shall contract with a national not-for-profit mental health organization to carry out a national program of training for veterans described in subsection (a) to provide the services described in subparagraphs (A) and (B) of paragraph (1) of such subsection.

(d) TRAINING OF CLINICIANS FOR PROVISION OF SERVICES.—The Secretary shall conduct a training program for clinicians of community mental health centers or entities that have contracts with the Secretary under subsection (b) to ensure that such clinicians can provide the services required by subsection (a) in a manner that—

(1) recognizes factors that are unique to the experience of veterans who served on active duty in Operation Iraqi Freedom or Operation Enduring Freedom (including their combat and military training experiences); and

(2) utilizes best practices and technologies.

(e) REPORTS REQUIRED.—

(1) INITIAL REPORT ON PLAN FOR IMPLEMENTATION.—Not later than 45 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing the plans of the Secretary to implement the program required by subsection (a).

(2) STATUS REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the implementation of the program. Such report shall include the following:

(A) Information on the number of veterans who received services as part of the program and the type of services received during the last full calendar year completed before the submission of such report.

(B) An evaluation of the provision of services under paragraph (2) of subsection (a) and a recommendation as to whether the period described in such paragraph should be extended to a five-year period.

SEC. 307. IMPROVEMENT OF CARE OF AMERICAN INDIAN VETERANS.

(a) INDIAN HEALTH COORDINATORS.—

(1) IN GENERAL.—Subchapter II of chapter 73 is amended by adding at the end the following new section:

''§ 7330B. Indian Veterans Health Care Coordinators

''(a) IN GENERAL.—(1) The Secretary shall assign at each of the 10 Department Medical Centers that serve communities with the greatest number of Indian veterans per capita an official or employee of the Department to act as the coordinator of health care for Indian veterans at such Medical Center. The official or employee so assigned at a Department Medical Center shall be known as the 'Indian Veterans Health Care Coordinator' for the Medical Center.

''(2) The Secretary shall, from time to time—

''(A) survey the Department Medical Centers for purposes of identifying the 10 Department Medical Centers that currently serve communities with the greatest number of Indian veterans per capita; and

''(B) utilizing the results of the most recent survey conducted under subparagraph (A), revise the assignment of Indian Veterans Health Care Coordinators in order to assure the assignment of such coordinators to appropriate Department Medical Centers as required by paragraph (1).

''(b) DUTIES.—The duties of an Indian Veterans Health Care Coordinator shall include the following:

''(1) Improving outreach to tribal communities.

''(2) Coordinating the medical needs of Indian veterans on Indian reservations with the Veterans Health Administration and the Indian Health Service.

''(3) Expanding the access and participation of the Department of Veterans Affairs, the Indian Health Service, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program.

''(4) Acting as an ombudsman for Indian veterans enrolled in the health care system of the Veterans Health Administration.

''(5) Advocating for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

''(c) INDIAN DEFINED.—In this section, the term 'Indian' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7330A the following new item:

''7330B. Indian Veterans Health Coordinators.''.

(b) INTEGRATION OF ELECTRONIC HEALTH RECORDS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health

and Human Services shall enter into a memorandum of understanding to ensure that the health records of Indian veterans may be transferred electronically between facilities of the Indian Health Service and the Department of Veterans Affairs.

(c) TRANSFER OF MEDICAL EQUIPMENT TO THE INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The Secretary of Veterans Affairs may transfer to the Indian Health Service such surplus Department of Veterans Affairs medical and information technology equipment as the Secretary of Veterans Affairs and the Secretary of Health and Human Services jointly consider appropriate for purposes of the Indian Health Service.

(2) TRANSPORTATION AND INSTALLATION.—In transferring medical or information technology equipment under this subsection, the Secretary of Veterans Affairs may transport and install such equipment in facilities of the Indian Health Service.

(d) REPORT ON JOINT HEALTH CLINICS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall jointly submit to Congress a report on the feasability and advisability of the joint establishment and operation by the Veterans Health Administration and the Indian Health Service of health clinics on Indian reservations to serve the populations of such reservations, including Indian veterans.

SEC. 308. TRAVEL REIMBURSEMENT FOR VETERANS RECEIVING TREATMENT AT FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) ENHANCEMENT OF ALLOWANCE BASED UPON MILEAGE TRAVELED.—Section 111 is amended—

(1) in subsection (a), by striking ''traveled,'' and inserting ''(at a rate of 41.5 cents per mile),''; and

(2) by amending subsection (g) to read as follows:

''(g)(1) Beginning one year after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary may adjust the mileage rate described in subsection (a) to be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a Government vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.

''(2) If an adjustment in the mileage rate under paragraph (1) results in a lower mileage rate than the mileage rate otherwise specified in subsection (a), the Secretary shall, not later than 60 days before the date of the implementation of the mileage rate as so adjusted, submit to Congress a written report setting forth the adjustment in the mileage rate under this subsection, together with a justification for the decision to make the adjustment in the mileage rate under this subsection.''.

(b) COVERAGE OF COST OF TRANSPORTATION BY AIR.—Subsection (a) of section 111, as amended by subsection (a)(1), is further amended by inserting after the first sentence the following new sentence: ''Actual necessary expense of travel includes the reasonable costs of airfare if travel by air is the only practical way to reach a Department facility.''.

(c) ELIMINATION OF LIMITATION BASED ON MAXIMUM ANNUAL RATE OF PENSION.—Subsection (b)(1)(D)(i) of such section is amended by inserting ''who is not traveling by air and'' before ''whose annual''.

(d) DETERMINATION OF PRACTICALITY.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

''(4) In determining for purposes of subsection (a) whether travel by air is the only practical way for a veteran to reach a Department facility, the Secretary shall consider the medical condition of the veteran and any other impediments to the use of ground transportation by the veteran.''.

(e) NO EXPANSION OF ELIGIBILITY FOR BENEFICIARY TRAVEL.—The amendments made by subsections (b) and (d) of this section may not be construed as expanding or otherwise modifying eligibility for payments or allowances for beneficiary travel under section 111 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act.

(f) CLARIFICATION OF RELATION TO PUBLIC TRANSPORTATION IN VETERANS HEALTH ADMINISTRATION HANDBOOK.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall revise the Veterans Health Administration Handbook to clarify that an allowance for travel based on mileage paid under section 111(a) of title 38, United States Code, may exceed the cost of such travel by public transportation regardless of medical necessity.

SEC. 309. OFFICE OF RURAL HEALTH FIVE-YEAR STRATEGIC PLAN.

(a) STRATEGIC PLAN.—Not later than 180 days after the date of the enactment of this Act, the Director of the Office of Rural Health of the Department of Veterans Affairs shall develop a five-year strategic plan for the Office of Rural Health.

(b) CONTENTS.—The plan required by subsection (a) shall include the following:

(1) Specific goals for the recruitment and retention of health care personnel in rural areas, developed in conjunction with the Director of the Health Care Retention and Recruitment Office of the Department of Veterans Affairs.

(2) Specific goals for ensuring the timeliness and quality of health care delivery in rural communities that are reliant on contract and fee-basis care, developed in conjunction with the Director of the Office of Quality and Performance of the Department.

(3) Specific goals for the expansion and implementation of telemedicine services in rural areas, developed in conjunction with the Director of the Office of Care Coordination Services of the Department.

(4) Incremental milestones describing specific actions to be taken for the purpose of achieving the goals specified under paragraphs (1) through (3).

SEC. 310. OVERSIGHT OF CONTRACT AND FEE-BASIS CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1703 the following new section:

''§ 1703A. Oversight of contract and fee-basis care

''(a) RURAL OUTREACH COORDINATORS.—The Secretary shall designate a rural outreach coordinator at each Department community based outpatient clinic at which not less than 50 percent of the veterans enrolled at such clinic reside in a highly rural area. The coordinator at a clinic shall be responsible for coordinating care and collaborating with community contract and fee-basis providers with respect to the clinic.

''(b) INCENTIVES TO OBTAIN ACCREDITATION OF MEDICAL PRACTICE.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department to encourage such providers to obtain accreditation of their medical practice from recognized accrediting entities.

''(2) In making adjustments under paragraph (1), the Secretary shall consider the increased overhead costs of accreditation described in paragraph (1) and the costs of achieving and maintaining such accreditation.

''(c) INCENTIVES FOR PARTICIPATION IN PEER REVIEW.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (e).

''(2) The Secretary shall provide incentives under paragraph (1) to a provider of health care services under the Department in an amount which may reasonably be expected (as determined by the Secretary) to encourage participation in the voluntary peer review under subsection (d).

''(d) PEER REVIEW.—(1) The Secretary shall provide for the voluntary peer review of providers of health care services under the Department who provide such services on a fee basis as part of a medical practice that is not accredited by a recognized accrediting entity.

''(2) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, the Chief Quality and Performance Officer in each Veterans Integrated Services Network (VISN) shall select a sample of patient records from each participating provider in the Officer's Veterans Integrated Services Network to be peer reviewed by a facility designated under paragraph (3).

''(3) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

''(4) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, each provider who elects to participate in the program shall submit the patient records selected under paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

''(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

''(A) peer review such records in accordance with policies and procedures established by the Secretary;

''(B) ensure that peer reviews are evaluated by the Peer Review Committee; and

''(C) develop a mechanism for notifying the Under Secretary for Health of problems identified through such peer review.

''(6) The Under Secretary for Health shall develop a mechanism by which the use of fee-basis providers of health care are terminated when quality of care concerns are identified with respect to such providers.

''(7) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall be responsible for the oversight of the program of peer review under this subsection in that network.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1703 the following new item:

''1703A. Oversight of contract and fee-basis care.''.

SEC. 311. ENHANCEMENT OF VET CENTERS TO MEET NEEDS OF VETERANS OF OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) VOLUNTEER COUNSELORS.—

(1) IN GENERAL.—Subsection (c) of section 1712A is amended—

(A) by striking ''The Under Secretary'' and inserting ''(1) The Under Secretary'';

(B) in paragraph (1), as designated by paragraph (1), by striking '', and, in carrying'' and all that follows through ''screening activities''; and

(C) by adding at the end the following new paragraphs:

''(2) In carrying out this section, the Under Secretary may utilize the services of the following:

''(A) Paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

''(B) Eligible volunteer counselors in the provision of counseling and related mental health services.

''(3) For purposes of this subsection, an eligible volunteer counselor is an individual—

''(A) who—

''(i) provides counseling services without compensation at a center;

''(ii) is a licensed psychologist or social worker;

''(iii) has never been named in a tort claim arising from professional activities; and

''(iv) has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

''(B) who is otherwise credentialed and privileged to perform counseling services by the Secretary.

''(4) Eligible volunteer counselors shall be issued credentials and privileges for the provision of counseling and related mental health services under this section on an expedited basis in accordance with such procedures as the Secretary shall establish. Such procedures shall provide for the completion by the Secretary of the processing of an application for such credentials and privileges not later than 60 days after receipt of the application.''.

(2) PROCEDURES FOR ISSUING CREDENTIALS AND PRIVILEGES TO VOLUNTEER COUNSELORS.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish the procedures described in section 1712A(c)(4), as added by paragraph (1).

(b) OUTREACH.—Subsection (e) of such section is amended—

(1) by striking ''The Secretary'' and inserting ''(1) The Secretary''; and

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

''(2) Each center shall develop an outreach plan to ensure that the community served by the center is aware of the services offered by the center.''.

SEC. 312. CENTERS OF EXCELLENCE FOR RURAL HEALTH RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES.

(a) IN GENERAL.—Subchapter II of chapter 73, as amended by section 307 of this Act, is further amended by adding at the end the following new section:

''§ 7330C. Centers of excellence for rural health research, education, and clinical activities

''(a) ESTABLISHMENT OF CENTERS.—The Secretary, through the Director of the Office of Rural Health, shall establish and operate at least one and not more than five centers of excellence for rural health research, education, and clinical activities, which shall—

''(1) conduct research on the furnishing of health services in rural areas;

''(2) develop specific models to be used by the Department in furnishing health services to veterans in rural areas;

''(3) provide education and training for health care professionals of the Department on the furnishing of health services to veterans in rural areas; and

''(4) develop and implement innovative clinical activities and systems of care for the Department for the furnishing of health services to veterans in rural areas.

''(b) USE OF RURAL HEALTH RESOURCE CENTERS.—In selecting locations for the establishment of centers of excellence under subsection (a), the Secretary may select a rural health resource center that meets the requirements of subsection (a).

''(c) GEOGRAPHIC DISPERSION.—The Secretary shall ensure that the centers established under this section are located at health care facilities that are geographically dispersed throughout the United States.

''(d) FUNDING.—(1) There are authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account of the Department of Veterans Affairs such sums as may be necessary for the support of the research and education activities of the centers operated under this section.

''(2) There shall be allocated to the centers operated under this section, from amounts authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account by paragraph (1), such amounts as the Under Secretary of health considers appropriate for such centers. Such amounts shall be allocated through the Director of the Office of Rural Health.

''(3) Activities of clinical and scientific investigation at each center operated under this section—

''(A) shall be eligible to compete for the award of funding from funds appropriated for the Medical and Prosthetics Research Account; and

''(B) shall receive priority in the award of funding from such account to the extent that funds are awarded to projects for research in the care of rural veterans.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73, as amended by section 307 of this Act, is further amended by inserting after the item relating to section 7330B the following new item:

''7330C. Centers of excellence for rural health research, education, and clinical activities.''.

SEC. 313. PILOT PROGRAM ON INCENTIVES FOR PHYSICIANS WHO ASSUME INPATIENT RESPONSIBILITIES AT COMMUNITY HOSPITALS IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasability and advisability of each of the following:

(1) The provision of financial incentives to eligible physicians who obtain and maintain inpatient privileges at community hospitals in health professional shortage areas in order to facilitate the provision by such physicians of primary care and mental health services to veterans at such hospitals.

(2) The collection of payments from third-party providers for care provided by eligible physicians to nonveterans while discharging inpatient responsibilities at community hospitals in the course of exercising the privileges described in paragraph (1).

(b) ELIGIBLE PHYSICIANS.—For purposes of this section, an eligible physician is a primary care or mental health physician employed by the Department of Veterans Affairs on a full-time basis.

(c) DURATION OF PROGRAM.—The pilot program shall be carried out during the three-year period beginning on the date of the commencement of the pilot program.

(d) LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at not less than five community hospitals in each of not less than two Veterans Integrated Services Networks (VISNs). The hospitals shall be selected by the Secretary utilizing the results of the survey required under subsection (e).

(2) QUALIFYING COMMUNITY HOSPITALS.—A community hospital may be selected by the Secretary as a location for the pilot program if—

(A) the hospital is located in a health professional shortage area; and

(B) the number of eligible physicians willing to assume inpatient responsibilities at the hospital (as determined utilizing the result of the survey) is sufficient for purposes of the pilot program.

(e) SURVEY OF PHYSICIAN INTEREST IN PARTICIPATION.—

(1) IN GENERAL.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall conduct a survey of eligible physicians to determine the extent of the interest of such physicians in participating in the pilot program.

(2) ELEMENTS.—The survey shall disclose the type, amount, and nature of the financial incentives to be provided under subsection (h) to physicians participating in the pilot program.

(f) PHYSICIAN PARTICIPATION.—

(1) IN GENERAL.—The Secretary shall select physicians for participation in the pilot program from among eligible physicians who—

(A) express interest in participating in the pilot program in the survey conducted under subsection (e);

(B) are in good standing with the Department; and

(C) primarily have clinical responsibilities with the Department.

(2) VOLUNTARY PARTICIPATION.—Participation in the pilot program shall be voluntary. Nothing in this section shall be construed to require a physician working for the Department to assume inpatient responsibilities at a community hospital unless otherwise required as a term or condition of employment with the Department.

(g) ASSUMPTION OF INPATIENT PHYSICIAN RESPONSIBILITIES.—

(1) IN GENERAL.—Each eligible physician selected for participation in the pilot program shall assume and maintain inpatient responsibilities, including inpatient responsibilities with respect to nonveterans, at one or more community hospitals selected by the Secretary for participation in the pilot program under subsection (d).

(2) COVERAGE UNDER FEDERAL TORT CLAIMS ACT.—If an eligible physician participating in the pilot program carries out on-call responsibilities at a community hospital where privileges to practice at such hospital are conditioned upon the provision of services to individuals who are not veterans while the physician is on call for such hospital, the provision of such services by the physician shall be considered an action within the scope of the physician's office or employment for purposes of chapter 171 of title 28, United States Code (commonly referred to as the ''Federal Tort Claims Act'').

(h) COMPENSATION.—

(1) IN GENERAL.—The Secretary shall provide each eligible physician participating in the pilot program with such compensation (including pay and other appropriate compensation) as the Secretary considers appropriate to compensate such physician for the discharge of any inpatient responsibilities by such physician at a community hospital for which such physician would not otherwise be compensated by the Department as a full-time employee of the Department.

(2) WRITTEN AGREEMENT.—The amount of any compensation to be provided a physician under the pilot program shall be specified in a written agreement entered into by the Secretary and the physician for purposes of the pilot program.

(3) TREATMENT OF COMPENSATION.—The Secretary shall consult with the Director of the Office of Personnel Management on the inclusion of a provision in the written agreement required under paragraph (2) that describes the treatment under Federal law of any compensation provided a physician under the pilot program, including treatment for purposes of retirement under the civil service laws.

(i) COLLECTIONS FROM THIRD PARTIES.—In carrying out the pilot program for the purpose described in subsection (a)(2), the Secretary shall implement a variety and range of requirements and mechanisms for the collection from third-party payors of amounts to reimburse the Department for health care services provided to nonveterans under the pilot program by eligible physicians discharging inpatient responsibilities under the pilot program.

(j) INPATIENT RESPONSIBILITIES DEFINED.—In this section, the term ''inpatient responsibilities'' means on-call responsibilities customarily required of a physician by a community hospital as a condition of granting privileges to the physician to practice in the hospital.

(k) REPORT.—Not later than one year after the date of the enactment of this Act and annually thereafter, the Secretary shall submit to Congress a report on the pilot program, including the following:

(1) The findings of the Secretary with respect to the pilot program.

(2) The number of veterans and nonveterans provided inpatient care by physicians participating in the pilot program.

(3) The amounts collected and payable under subsection (i).

(l) HEALTH PROFESSIONAL SHORTAGE AREA DEFINED.—In this section, the term ''health professional shortage area'' has the meaning given the term in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)).

SEC. 314. ANNUAL REPORT ON MATTERS RELATED TO CARE FOR VETERANS WHO LIVE IN RURAL AREAS.

(a) ANNUAL REPORT.—The Secretary of Veterans Affairs shall submit to Congress each year, together with documents submitted to Congress in support of the budget of the President for the fiscal year beginning in such year (as submitted pursuant to section 1105 of title 31, United States Code), an assessment, current as of the fiscal year ending in the year before such report is submitted, of the following:

(1) The implementation of the provisions of sections 209 through 213, including the amendments made by such sections.

(2) The establishment and functions of the Office of Rural Health under section 7308 of title 38, United States Code.

(b) ADDITIONAL REQUIREMENTS FOR INITIAL REPORT.—The first report submitted under subsection (a) shall also include the following:

(1) The assessment of fee-basis health-care program required by section 212(b) of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461; 120 Stat. 3422).

(2) An assessment of the outreach program required by section 213 of such Act (120 Stat. 3422; 38 U.S.C. 6303 note).

SEC. 315. TRANSPORTATION GRANTS FOR RURAL VETERANS SERVICE ORGANIZATIONS.

(a) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall establish a grant program to provide innovative transportation options to veterans in highly rural areas.

(2) ELIGIBLE RECIPIENTS.—The following may be awarded a grant under this section:

(A) State veterans service agencies.

(B) Veterans service organizations.

(3) USE OF FUNDS.—A State veterans service agency or veterans service organization awarded a grant under this section may use the grant amount to—

(A) assist veterans in highly rural areas to travel to Department of Veterans Affairs medical centers; and

(B) otherwise assist in providing medical care to veterans in highly rural areas.

(4) MAXIMUM AMOUNT.—The amount of a grant under this section may not exceed $50,000.

(5) NO MATCHING REQUIREMENT.—The recipient of a grant under this section shall not be required to provide matching funds as a condition for receiving such grant.

(b) REGULATIONS.—The Secretary shall prescribe regulations for—

(1) evaluating grant applications under this section; and

(2) otherwise administering the program established by this section.

(c) DEFINITIONS.—In this section:

(1) HIGHLY RURAL.—The term ''highly rural'', in the case of an area, means that the area consists of a county or counties having a population of less than seven persons per square mile.

(2) VETERANS SERVICE ORGANIZATION.—The term ''veterans service organization'' means any organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 for each of fiscal years 2010 through 2014 to carry out this section.

SEC. 316. MODIFICATION OF ELIGIBILITY FOR PARTICIPATION IN PILOT PROGRAM OF ENHANCED CONTRACT CARE AUTHORITY FOR HEALTH CARE NEEDS OF CERTAIN VETERANS.

Section 403(b) of the Veterans' Mental Health and other Care Improvements Act of 2008 (Public Law 110–387; 122 Stat. 4125; 38 U.S.C. 1703 note) is amended to read as follows:

''(b) COVERED VETERANS.—For purposes of the pilot program under this section, a covered veteran is any veteran who—

''(1) is—

''(A) enrolled in the system of patient enrollment established under section 1705(a) of title 38, United States Code, as of the date of the commencement of the pilot program under subsection (a)(2); or

''(B) eligible for health care under section 1710(e)(3)(C) of title 38, United States Code; and

''(2) resides in a location that is—

''(A) more than 60 minutes driving distance from the nearest Department health care facility providing primary care services, if the veteran is seeking such services;

''(B) more than 120 minutes driving distance from the nearest Department health care facility providing acute hospital care, if the veteran is seeking such care; or

''(C) more than 240 minutes driving distance from the nearest Department health care facility providing tertiary care, if the veteran is seeking such care.''.

TITLE IV—MENTAL HEALTH CARE MATTERS

SEC. 401. ELIGIBILITY OF MEMBERS OF THE ARMED FORCES WHO SERVE IN OPERATION IRAQI FREEDOM OR OPERATION ENDURING FREEDOM FOR COUNSELING AND SERVICES THROUGH READJUSTMENT COUNSELING SERVICE.

(a) IN GENERAL.—Any member of the Armed Forces, including a member of the National Guard or Reserve, who serves on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom is eligible for readjustment counseling and related mental health services under section 1712A of title 38, United States Code, through the Readjustment Counseling Service of the Veterans Health Administration.

(b) NO REQUIREMENT FOR CURRENT ACTIVE DUTY SERVICE.—A member of the Armed Forces who meets the requirements for eligibility for counseling and services under subsection (a) is entitled to counseling and services under that subsection regardless of whether or not the member is currently on active duty in the Armed Forces at the time of receipt of counseling and services under that subsection.

(c) REGULATIONS.—The eligibility of members of the Armed Forces for counseling and services under subsection (a) shall be subject to such regulations as the Secretary of Defense and the Secretary of Veterans Affairs shall jointly prescribe for purposes of this section.

(d) SUBJECT TO AVAILABILITY OF APPROPRIATIONS.—The provision of counseling and services under subsection (a) shall be subject to the availability of appropriations for such purpose.

SEC. 402. RESTORATION OF AUTHORITY OF READJUSTMENT COUNSELING SERVICE TO PROVIDE REFERRAL AND OTHER ASSISTANCE UPON REQUEST TO FORMER MEMBERS OF THE ARMED FORCES NOT AUTHORIZED COUNSELING.

Section 1712A is amended—

(1) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively; and

(2) by inserting after subsection (b) the following new subsection (c):

''(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not otherwise eligible for such counseling, the Secretary shall—

''(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

''(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service, and to the Department, for review of such individual's discharge or release from such service.''.

SEC. 403. STUDY ON SUICIDES AMONG VETERANS.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall conduct a study to determine the number of veterans who died by suicide between January 1, 1999, and the date of the enactment of this Act.

(b) COORDINATION.—In carrying out the study under subsection (a) the Secretary of Veterans Affairs shall coordinate with—

(1) the Secretary of Defense;

(2) Veterans Service Organizations;

(3) the Centers for Disease Control and Prevention; and

(4) State public health offices and veterans agencies.

(c) REPORT TO CONGRESS.—The Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the study required under subsection (a) and the findings of the Secretary.

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

SEC. 404. TRANSFER OF FUNDS TO SECRETARY OF HEALTH AND HUMAN SERVICES FOR GRADUATE PSYCHOLOGY EDUCATION PROGRAM.

(a) TRANSFER OF FUNDS.—Not later than September 30, 2010, the Secretary of Veterans Affairs shall transfer $5,000,000 from accounts of the Veterans Health Administration to the Secretary of Health and Human Services for the Graduate Psychology Education program established under section 755(b)(1)(J) of the Public Health Service Act (42 U.S.C. 294e(b)(1)(J)).

(b) USE OF FUNDS TRANSFERRED.—Funds transferred under subsection (a) shall be used

to award grants to support the training of psychologists in the treatment of veterans with post traumatic stress disorder, traumatic brain injury, and other combat-related disorders.

(c) PREFERENCE FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITIES.—In the awarding of grants under subsection (b), the Graduate Psychology Education program shall give preference to health care facilities of the Department of Veterans Affairs and graduate programs of education that are affiliated with such facilities.

TITLE V—OTHER HEALTH CARE MATTERS

SEC. 501. REPEAL OF CERTAIN ANNUAL REPORTING REQUIREMENTS.

(a) NURSE PAY REPORT.—Section 7451 is amended—

(1) by striking subsection (f); and

(2) by redesignating subsection (g) as subsection (f).

(b) LONG-TERM PLANNING REPORT.—

(1) IN GENERAL.—Section 8107 is repealed.

(2) CONFORMING AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by striking the item relating to section 8107.

SEC. 502. MODIFICATIONS TO ANNUAL GULF WAR RESEARCH REPORT.

Section 707(c)(1) of the Persian Gulf War Veterans' Health Status Act (title VII of Public Law 102–585; 38 U.S.C. 527 note) is amended by striking ''Not later than March 1 of each year'' and inserting ''Not later than July 1, 2010, and July 1 of each of the five following years''.

SEC. 503. PAYMENT FOR CARE FURNISHED TO CHAMPVA BENEFICIARIES.

Section 1781 is amended at the end by adding the following new subsection:

''(e) Payment by the Secretary under this section on behalf of a covered beneficiary for medical care shall constitute payment in full and extinguish any liability on the part of the beneficiary for that care.''.

SEC. 504. DISCLOSURES FROM CERTAIN MEDICAL RECORDS.

Section 7332(b)(2) is amended by adding at the end the following new subparagraph:

''(F)(i) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given record necessary for that representative to make an informed decision regarding the patient's treatment.

''(ii) In this subparagraph, the term 'representative' means an individual, organization, or other body authorized under section 7331 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.''.

SEC. 505. DISCLOSURE TO SECRETARY OF HEALTH-PLAN CONTRACT INFORMATION AND SOCIAL SECURITY NUMBER OF CERTAIN VETERANS RECEIVING CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

''§ 1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care

''(a) REQUIRED DISCLOSURE OF HEALTH-PLAN CONTRACTS.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary such current information as the Secretary may require to identify any health-plan contract (as defined in section 1729(i) of this title) under which such individual is covered, to include, as applicable—

''(A) the name, address, and telephone number of such health-plan contract;

''(B) the name of the individual's spouse, if the individual's coverage is under the spouse's health-plan contract;

''(C) the plan number; and

''(D) the plan's group code.

''(2) The care described in this paragraph is—

''(A) hospital, nursing home, or domiciliary care;

''(B) medical, rehabilitative, or preventive health services; or

''(C) other medical care under laws administered by the Secretary.

''(b) REQUIRED DISCLOSURE OF SOCIAL SECURITY NUMBER.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

''(A) the individual's social security number; and

''(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

''(2) The care described in this paragraph is—

''(A) hospital, nursing home, or domiciliary care;

''(B) medical, rehabilitative, or preventive health services; or

''(C) other medical care under laws administered by the Secretary.

''(3) This subsection does not require an individual to furnish the Secretary with a social security number for any individual to whom a social security number has not been assigned.

''(c) FAILURE TO DISCLOSE SOCIAL SECURITY NUMBER.—(1) The Secretary shall deny an individual's application for, or may terminate an individual's enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to subsection (b).

''(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual's application or reinstate such individual's enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as authority to deny medical care and treatment to an individual in a medical emergency.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter 17 is amended by inserting after the item relating to section 1708 the following new item:

''1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.''.

SEC. 506. ENHANCEMENT OF QUALITY MANAGEMENT.

(a) ENHANCEMENT OF QUALITY MANAGEMENT THROUGH QUALITY MANAGEMENT OFFICERS.—

(1) IN GENERAL.—Subchapter II of chapter 73 is amended by inserting after section 7311 the following new section:

''§ 7311A. Quality management officers

''(a) NATIONAL QUALITY MANAGEMENT OFFICER.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality management officer for the quality-assurance program required by section 7311 of this title. The official so designated may be known as the 'National Quality Management Officer of the Veterans Health Administration' (in this section referred to as the 'National Quality Management Officer').

''(2) The National Quality Management Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

''(3) The National Quality Management Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality-assurance program referred to in paragraph (1). In carrying out that responsibility, the Officer shall be responsible for the following:

''(A) Establishing and enforcing the requirements of the program referred to in paragraph (1).

''(B) Developing an aggregate quality metric from existing data sources, such as the Inpatient Evaluation Center of the Department, the National Surgical Quality Improvement Program, and the External Peer Review Program of the Veterans Health Administration, that could be used to assess reliably the quality of care provided at individual Department medical centers and associated community based outpatient clinics.

''(C) Ensuring that existing measures of quality, including measures from the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, System-Wide Ongoing Assessment and Review reports of the Department, and Combined Assessment Program reviews of the Office of Inspector General of the Department, are monitored routinely and analyzed in a manner that ensures the timely detection of quality of care issues.

''(D) Encouraging research and development in the area of quality metrics for the purposes of improving how the Department measures quality in individual facilities.

''(E) Carrying out such other responsibilities and duties relating to quality management in the Veterans Health Administration as the Under Secretary for Health shall specify.

''(4) The requirements under paragraph (3) shall include requirements regarding the following:

''(A) A confidential system for the submittal of reports by Veterans Health Administration personnel regarding quality management at Department facilities.

''(B) Mechanisms for the peer review of the actions of individuals appointed in the Veterans Health Administration in the position of physician.

''(b) QUALITY MANAGEMENT OFFICERS FOR VISNS.—(1) The Regional Director of each Veterans Integrated Services Network (VISN) shall appoint an official of the Network to act as the quality management officer of the Network.

''(2) The quality management officer for a Veterans Integrated Services Network shall report to the Regional Director of the Veterans Integrated Services Network, and to the National Quality Management Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

''(3) The quality management officer for a Veterans Integrated Services Network shall—

''(A) direct the quality management office in the Network; and

''(B) coordinate, monitor, and oversee the quality management programs and activities of the Administration medical facilities in the Network in order to ensure the thorough and uniform discharge of quality management requirements under such programs and activities throughout such facilities.

''(c) QUALITY MANAGEMENT OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality management officer for that facility.

''(2) The quality management officer for a facility shall report directly to the director of the facility, and to the quality management officer of the Veterans Integrated

Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality management officer under this section.

''(3) The quality management officer for a facility shall be responsible for designing, disseminating, and implementing quality management programs and activities for the facility that meet the requirements established by the National Quality Management Officer under subsection (a).

''(d) AUTHORIZATION OF APPROPRIATIONS.—(1) Except as provided in paragraph (2), there are authorized to be appropriated such sums as may be necessary to carry out this section.

''(2) There are authorized to be appropriated to carry out the provisions of subparagraphs (B), (C), and (D) of subsection (a)(3), $25,000,000 for the two-year period of fiscal years beginning after the date of the enactment of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7311 the following new item:

''7311A. Quality management officers.''.

(b) REPORTS ON QUALITY CONCERNS UNDER QUALITY-ASSURANCE PROGRAM.—Section 7311(b) is amended by adding at the end the following new paragraph:

''(4) As part of the quality-assurance program, the Under Secretary for Health shall establish mechanisms through which employees of Veterans Health Administration facilities may submit reports, on a confidential basis, on matters relating to quality of care in Veterans Health Administration facilities to the quality management officers of such facilities under section 7311A(b) of this title. The mechanisms shall provide for the prompt and thorough review of any reports so submitted by the receiving officials.''.

(c) REVIEW OF CURRENT HEALTH CARE QUALITY SAFEGUARDS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a comprehensive review of all current policies and protocols of the Department of Veterans Affairs for maintaining health care quality and patient safety at Department medical facilities. The review shall include a review and assessment of the National Surgical Quality Improvement Program (NSQIP), including an assessment of—

(A) the efficacy of the quality indicators under the program;

(B) the efficacy of the data collection methods under the program;

(C) the efficacy of the frequency with which regular data analyses are performed under the program; and

(D) the extent to which the resources allocated to the program are adequate to fulfill the stated function of the program.

(2) REPORT.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the review conducted under paragraph (1), including the findings of the Secretary as a result of the review and such recommendations as the Secretary considers appropriate in light of the review.

SEC. 507. REPORTS ON IMPROVEMENTS TO DEPARTMENT HEALTH CARE QUALITY MANAGEMENT.

(a) REPORT.—Not later than December 15, 2010, and each year thereafter through 2012, the Secretary of Veterans Affairs shall submit to the congressional veterans affairs committees a report on the implementation of sections 604 and 506 of this Act and the amendments made by such sections during the preceding fiscal year. Each report shall include, for the fiscal year covered by such report, the following:

(1) A comprehensive description of the implementation of sections 604 and 506 of this Act and the amendments made by such sections.

(2) Such recommendations as the Secretary considers appropriate for legislative or administrative action to improve the authorities and requirements in such sections and the amendments made by such sections or to otherwise improve the quality of health care and the quality of the physicians in the Veterans Health Administration.

(b) CONGRESSIONAL VETERANS AFFAIRS COMMITTEES DEFINED.—In this section, the term ''congressional veterans affairs committees'' means—

(1) the Committees on Veterans' Affairs and Appropriations of the Senate; and

(2) the Committees on Veterans' Affairs and Appropriations of the House of Representatives.

SEC. 508. PILOT PROGRAM ON USE OF COMMUNITY-BASED ORGANIZATIONS AND LOCAL AND STATE GOVERNMENT ENTITIES TO ENSURE THAT VETERANS RECEIVE CARE AND BENEFITS FOR WHICH THEY ARE ELIGIBLE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of using community-based organizations and local and State government entities—

(1) to increase the coordination of community, local, State, and Federal providers of health care and benefits for veterans to assist veterans who are transitioning from military service to civilian life in such transition;

(2) to increase the availability of high quality medical and mental health services to veterans transitioning from military service to civilian life;

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life to help such families adjust to such transition; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) CONSIDERATIONS.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(e) SELECTION OF GRANT RECIPIENTS.—

(1) IN GENERAL.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELEMENTS.—Each application submitted under paragraph (1) shall include the following:

(A) A description of how the proposal was developed in consultation with the Department of Veterans Affairs.

(B) A plan to coordinate activities under the pilot program, to the greatest extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effect of such services.

(f) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(g) REPORT ON PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program.

(B) An assessment of the benefits to veterans of the pilot program.

(C) The recommendations of the Secretary as to the advisability of continuing the pilot program.

SEC. 509. SPECIALIZED RESIDENTIAL CARE AND REHABILITATION FOR CERTAIN VETERANS.

Section 1720 is amended by adding at the end the following new subsection:

''(g) The Secretary may contract with appropriate entities to provide specialized residential care and rehabilitation services to a veteran of Operation Enduring Freedom or Operation Iraqi Freedom who the Secretary determines suffers from a traumatic brain injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and because of these deficits, would otherwise require admission to a nursing home even though such care would generally exceed the veteran's nursing needs.''.

SEC. 510. EXPANDED STUDY ON THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD).

(b) COVERED VETERANS.—The study required by subsection (a) shall include, to the extent practicable, all veterans who participated in Project Shipboard Hazard and Defense.

(c) UTILIZATION OF EXISTING STUDIES.—The study required by subsection (a) may use results from the study covered in the report entitled ''Long-Term Health Effects of Participation in Project SHAD'' of the Institute of Medicine of the National Academies.

SEC. 511. USE OF NON-DEPARTMENT FACILITIES FOR REHABILITATION OF INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

Section 1710E is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection (b):

''(b) COVERED INDIVIDUALS.—The care and services provided under subsection (a) shall be made available to an individual—

''(1) who is described in section 1710C(a) of this title; and

''(2)(A) to whom the Secretary is unable to provide such treatment or services at the frequency or for the duration prescribed in such plan; or

''(B) for whom the Secretary determines that it is optimal with respect to the recovery and rehabilitation for such individual.''; and

(3) by adding at the end the following new subsection:

''(d) STANDARDS.—The Secretary may not provide treatment or services as described in subsection (a) at a non-Department facility under such subsection unless such facility maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.''.

SEC. 512. INCLUSION OF FEDERALLY RECOGNIZED TRIBAL ORGANIZATIONS IN CERTAIN PROGRAMS FOR STATE VETERANS HOMES.

(a) TREATMENT OF TRIBAL ORGANIZATION HEALTH FACILITIES AS STATE HOMES.—Section 8138 is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection (e):

''(e)(1) A health facility (or certain beds in a health facility) of a tribal organization is treatable as a State home under subsection (a) in accordance with the provisions of that subsection.

''(2) Except as provided in paragraph (3), the provisions of this section shall apply to a health facility (or certain beds in such facility) treated as a State home under subsection (a) by reason of this subsection to the same extent as health facilities (or beds) treated as a State home under subsection (a).

''(3) Subsection (f) shall not apply to the treatment of health facilities (or certain beds in such facilities) of tribal organizations as a State home under subsection (a).''.

(b) STATE HOME FACILITIES FOR DOMICILIARY, NURSING, AND OTHER CARE.—

(1) IN GENERAL.—Chapter 81 is further amended—

(A) in section 8131, by adding at the end the following new paragraph:

''(5) The term 'tribal organization' has the meaning given such term in section 3765 of this title.'';

(B) in section 8132, by inserting ''and tribal organizations'' after ''the several States''; and

(C) by inserting after section 8133 the following new section:

''§ 8133A. Tribal organizations

''(a) AUTHORITY TO AWARD GRANTS.—The Secretary may award a grant to a tribal organization under this subchapter in order to carry out the purposes of this subchapter.

''(b) MANNER AND CONDITION OF GRANT AWARDS.—(1) Grants to tribal organizations under this section shall be awarded in the same manner, and under the same conditions, as grants awarded to the several States under the provisions of this subchapter, subject to such exceptions as the Secretary shall prescribe for purposes of this subchapter to take into account the unique circumstances of tribal organizations.

''(2) For purposes of according priority under subsection (c)(2) of section 8135 of this title to an application submitted under subsection (a) of such section, an application submitted under such subsection (a) by a tribal organization of a State that has previously applied for award of a grant under this subchapter for construction or acquisition of a State nursing home shall be considered under subparagraph (C) of such subsection (c)(2) an application from a tribal organization that has previously applied for such a grant.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by inserting after the item relating to section 8133 the following new item:

''8133A. Tribal organizations.''.

SEC. 513. PILOT PROGRAM ON PROVISION OF DENTAL INSURANCE PLANS TO VETERANS AND SURVIVORS AND DEPENDENTS OF VETERANS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b).

(b) COVERED VETERANS AND SURVIVORS AND DEPENDENTS.—The veterans and survivors and dependents of veterans described in this subsection are as follows:

(1) Any veteran who is enrolled in the system of annual patient enrollment under section 1705 of this title.

(2) Any survivor or dependent of a veteran who is eligible for medical care under section 1781 of this title.

(c) DURATION OF PROGRAM.—The pilot program shall be carried out during the three-year period beginning on the date of the enactment of this Act.

(d) PILOT PROGRAM LOCATIONS.—The pilot program shall be carried out in not less than two and not more than four Veterans Integrated Services Networks (VISNs) selected by the Secretary of Veterans Affairs for purposes of the pilot program.

(e) ADMINISTRATION.—The Secretary of Veterans Affairs shall contract with a dental insurer to administer the dental plan provided under the pilot program.

(f) BENEFITS.—The dental insurance plan under the pilot program shall provide such benefits for dental care and treatment as the Secretary considers appropriate for the dental insurance plan, including diagnostic services, preventative services, endodontics and other restorative services, surgical services, and emergency services.

(g) ENROLLMENT.—

(1) VOLUNTARY.—Enrollment in the dental insurance plan under this section shall be voluntary.

(2) MINIMUM PERIOD.—Enrollment in the dental insurance plan shall be for such minimum period as the Secretary shall prescribe for purposes of this section.

(h) PREMIUMS.—

(1) IN GENERAL.—Premiums for coverage under the dental insurance plan under the pilot program shall be in such amount or amounts as the Secretary of Veterans Affairs shall prescribe to cover all costs associated with the pilot program.

(2) ANNUAL ADJUSTMENT.—The Secretary shall adjust the premiums payable under the pilot program for coverage under the dental insurance plan on an annual basis. Each individual covered by the dental insurance plan at the time of such an adjustment shall be notified of the amount and effective date of such adjustment.

(3) RESPONSIBILITY FOR PAYMENT.—Each individual covered by the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan, in addition to the full cost of any copayments.

(i) VOLUNTARY DISENROLLMENT.—

(1) IN GENERAL.—With respect to enrollment in the dental insurance plan under the pilot program, the Secretary shall—

(A) permit the voluntary disenrollment of an individual in the dental insurance plan if the disenrollment occurs during the 30-day period beginning on the date of the enrollment of the individual in the dental insurance plan; and

(B) permit the voluntary disenrollment of an individual in the dental insurance plan for such circumstances as the Secretary shall prescribe for purposes of this subsection, but only to the extent such disenrollment does not jeopardize the fiscal integrity of the dental insurance plan.

(2) ALLOWABLE CIRCUMSTANCES.—The circumstances prescribed under paragraph (1)(B) shall include the following:

(A) If an individual enrolled in the dental insurance plan relocates to a location outside the jurisdiction of the dental insurance plan that prevents utilization of the benefits under the dental insurance plan.

(B) If an individual enrolled in the dental insurance plan is prevented by a serious medical condition from being able to obtain benefits under the dental insurance plan.

(C) Such other circumstances as the Secretary shall prescribe for purposes of this subsection.

(3) ESTABLISHMENT OF PROCEDURES.—The Secretary shall establish procedures for determinations on the permissibility of voluntary disenrollments under paragraph (1)(B). Such procedures shall ensure timely determinations on the permissibility of such disenrollments.

(j) RELATIONSHIP TO DENTAL CARE PROVIDED BY SECRETARY.—Nothing in this section shall affect the responsibility of the Secretary to provide dental care under section 1712 of title 38, United States Code, and the participation of an individual in the dental insurance plan under the pilot program shall not affect the individual's entitlement to outpatient dental services and treatment, and related dental appliances, under that section.

(k) REGULATIONS.—The dental insurance plan under the pilot program shall be administered under such regulations as the Secretary shall prescribe.

SEC. 514. EXPANSION OF VETERAN ELIGIBILITY FOR REIMBURSEMENT BY SECRETARY OF VETERANS AFFAIRS FOR EMERGENCY TREATMENT FURNISHED IN A NON-DEPARTMENT FACILITY.

(a) EXPANSION OF ELIGIBILITY.—Subsection (b)(3)(C) of section 1725 is amended by striking '', in whole or in part,''.

(b) LIMITATIONS ON REIMBURSEMENT.—Section 1725 is further amended—

(1) in subsection (c), by adding at the end the following new paragraph:

''(4)(A) If the veteran has contractual or legal recourse against a third party that would, in part, extinguish the veteran's liability to the provider of the emergency treatment and payment for the treatment may be made both under subsection (a) and by the third party, the amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).

''(B) In any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary shall be the secondary payer.

''(C) A payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider.

''(D) The Secretary may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract.''; and

(2) in subsection (f)(3)—

(A) in subparagraph (A), by inserting before the period at the end the following: '', including the Secretary of Health and Human Services with respect to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.)''; and

(B) in subparagraph (B), by inserting before the period at the end the following: '', including a State Medicaid agency with respect to payments made under a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act, and shall apply with respect to emergency treatment furnished on or after that date.

(2) REIMBURSEMENT FOR TREATMENT BEFORE EFFECTIVE DATE.—The Secretary of Veterans Affairs may provide reimbursement under section 1725 of title 38, United States Code, as amended by this subsection, for emergency treatment furnished before the date of the enactment of this Act if the Secretary determines that, under the circumstances applicable with respect to the veteran, it is appropriate to do so.

SEC. 515. PROHIBITION ON COLLECTION OF COPAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED.

(a) IN GENERAL.—Subchapter III of chapter 17 is amended by adding at the end the following new section:

''§ 1730A. Prohibition on collection of copayments from catastrophically disabled veterans

''Notwithstanding subsections (f) and (g) of section 1710 and section 1722A(a) of this title or any other provision of law, the Secretary may not require a veteran who is catastrophically disabled to make any copayment for the receipt of hospital care or medical services under the laws administered by the Secretary.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1730 the following new item:

''1730A. Prohibition on collection of copayments from catastrophically disabled veterans.''.

TITLE VI—DEPARTMENT PERSONNEL MATTERS

SEC. 601. ENHANCEMENT OF AUTHORITIES FOR RETENTION OF MEDICAL PROFESSIONALS.

(a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.—

(1) IN GENERAL.—Paragraph (3) of section 7401 is amended by striking ''and blind rehabilitation outpatient specialists.'' and inserting the following: ''blind rehabilitation outpatient specialists, and such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department subject to the following requirements:

''(A) Such other classes of health care occupations—

''(i) are not occupations relating to administrative, clerical, or physical plant maintenance and protective services;

''(ii) that would otherwise receive basic pay in accordance with the General Schedule under section 5332 of title 5;

''(iii) provide, as determined by the Secretary, direct patient care services or services incident to direct patient services; and

''(iv) would not otherwise be available to provide medical care or treatment for veterans.

''(B) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Office of Management and Budget notice of such appointment.

''(C) Before submitting notice under subparagraph (B), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice.''.

(2) APPOINTMENT OF NURSE ASSISTANTS.—Such paragraph is further amended by inserting ''nurse assistants,'' after ''licensed practical or vocational nurses,''.

(b) PROBATIONARY PERIODS FOR REGISTERED NURSES.—Section 7403(b) is amended—

(1) in paragraph (1), by striking ''Appointments'' and inserting ''Except as otherwise provided in this subsection, appointments'';

(2) by redesignating paragraph (2) as paragraph (4); and

(3) by inserting after paragraph (1) the following new paragraphs:

''(2) With respect to the appointment of a registered nurse under this chapter, paragraph (1) shall apply with respect to such appointment regardless of whether such appointment is on a full-time basis or a part-time basis.

''(3) An appointment described in subsection (a) on a part-time basis of a person who has previously served on a full-time basis for the probationary period for the position concerned shall be without a probationary period.''.

(c) PROHIBITION ON TEMPORARY PART-TIME REGISTERED NURSE APPOINTMENTS IN EXCESS OF TWO YEARS.—Section 7405 is amended by adding at the end the following new subsection:

''(g)(1) Except as provided in paragraph (3), employment of a registered nurse on a temporary part-time basis under subsection (a)(1) shall be for a probationary period of two years.

''(2) Except as provided in paragraph (3), upon completion by a registered nurse of the probationary period described in paragraph (1)—

''(A) the employment of such nurse shall—

''(i) no longer be considered temporary; and

''(ii) be considered an appointment described in section 7403(a) of this title; and

''(B) the nurse shall be considered to have served the probationary period required by section 7403(b).

''(3) This subsection shall not apply to appointments made on a term limited basis of less than or equal to three years of—

''(A) nurses with a part-time appointment resulting from an academic affiliation or teaching position in a nursing academy of the Department;

''(B) nurses appointed as a result of a specific research proposal or grant; or

''(C) nurses who are not citizens of the United States and appointed under section 7407(a) of this title.''.

(d) WAIVER OF OFFSET FROM PAY FOR CERTAIN REEMPLOYED ANNUITANTS.—

(1) IN GENERAL.—Section 7405, as amended by subsection (c), is further amended by adding at the end the following new subsection:

''(h)(1) The Secretary may waive the application of sections 8344 and 8468 of title 5 (relating to annuities and pay on reemployment) or any other similar provision of law under a Government retirement system on a case-by-case basis for an annuitant reemployed on a temporary basis under the authority of subsection (a) in a position described under paragraph (1) of that subsection.

''(2) An annuitant to whom a waiver under paragraph (1) is in effect shall not be considered an employee for purposes of any Government retirement system.

''(3) An annuitant to whom a waiver under paragraph (1) is in effect shall be subject to the provisions of chapter 71 of title 5 (including all labor authority and labor representative collective bargaining agreements) applicable to the position to which appointed.

''(4) In this subsection:

''(A) The term 'annuitant' means an annuitant under a Government retirement system.

''(B) The term 'employee' has the meaning under section 2105 of title 5.

''(C) The term 'Government retirement system' means a retirement system established by law for employees of the Government of the United States.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date that is 180 days after the date of the enactment of this Act, and shall apply to pay periods beginning on or after such effective date.

(e) RATE OF BASIC PAY FOR APPOINTEES TO THE OFFICE OF THE UNDER SECRETARY FOR HEALTH SET TO RATE OF BASIC PAY FOR SENIOR EXECUTIVE SERVICE POSITIONS.—

(1) IN GENERAL.—Section 7404(a) is amended—

(A) by striking ''The annual'' and inserting ''(1) The annual'';

(B) by striking ''The pay'' and inserting the following:

''(2) The pay'';

(C) by striking ''under the preceding sentence'' and inserting ''under paragraph (1)''; and

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

''(3)(A) The rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) shall be set in accordance with section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

''(B) A rate of basic pay for a position may not be set under subparagraph (A) in excess of—

''(i) in the case the position is not described in clause (ii), the rate of basic pay payable for level III of the Executive Schedule; or

''(ii) in the case that the position is covered by a performance appraisal system that meets the certification criteria established by regulation under section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.

''(C) Notwithstanding the provisions of subsection (d) of section 5307 of title 5, the Secretary may make any certification under that subsection instead of the Office of Personnel Management and without concurrence of the Office of Management and Budget.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the first day of the first pay period beginning after the day that is 180 days after the date of the enactment of this Act.

(f) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—Section 7410 is amended—

(1) by striking ''The Secretary may'' and inserting the following:

''(a) IN GENERAL.—The Secretary may''; and

(2) by adding at the end the following new subsection:

''(b) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—(1) In order to recruit and retain highly qualified Department pharmacist executives, the Secretary may authorize the Under Secretary for Health to pay special incentive pay of not more than $40,000 per year to an individual of the Veterans Health Administration who is a pharmacist executive.

''(2) In determining whether and how much special pay to provide to such individual, the Under Secretary shall consider the following:

''(A) The grade and step of the position of the individual.

''(B) The scope and complexity of the position of the individual.

''(C) The personal qualifications of the individual.

''(D) The characteristics of the labor market concerned.

''(E) Such other factors as the Secretary considers appropriate.

''(3) Special incentive pay under paragraph (1) for an individual is in addition to all other pay (including basic pay) and allowances to which the individual is entitled.

''(4) Except as provided in paragraph (5), special incentive pay under paragraph (1) for an individual shall be considered basic pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, and other benefits.

''(5) Special incentive pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under subchapter V of this chapter.

''(6) Special incentive pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.''.

(g) PAY FOR PHYSICIANS AND DENTISTS.—

(1) NON-FOREIGN COST OF LIVING ADJUSTMENT ALLOWANCE.—Section 7431(b) is amended by adding at the end the following new paragraph:

''(5) The non-foreign cost of living adjustment allowance authorized under section 5941 of title 5 for physicians and dentists whose pay is set under this section shall be determined as a percentage of base pay only.''.

(2) MARKET PAY DETERMINATIONS FOR PHYSICIANS AND DENTISTS IN ADMINISTRATIVE OR EXECUTIVE LEADERSHIP POSITIONS.—Section 7431(c)(4)(B)(i) is amended by adding at the end the following: ''The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.''.

(3) EXCEPTION TO PROHIBITION ON REDUCTION OF MARKET PAY.—Section 7431(c)(7) is amended by striking ''concerned.'' and inserting ''concerned, unless there is a change in board certification or reduction of privileges.''.

(h) ADJUSTMENT OF PAY CAP FOR NURSES.—Section 7451(c)(2) is amended by striking ''level V'' and inserting ''level IV''.

(i) EXEMPTION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS FROM LIMITATION ON AUTHORIZED COMPETITIVE PAY.—Section 7451(c)(2) is further amended by adding at the end the following new sentence: ''The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.''.

(j) INCREASED LIMITATION ON SPECIAL PAY FOR NURSE EXECUTIVES.—Section 7452(g)(2) is amended by striking ''$25,000'' and inserting ''$100,000''.

(k) LOCALITY PAY SCALE COMPUTATIONS.—

(1) EDUCATION, TRAINING, AND SUPPORT FOR FACILITY DIRECTORS IN WAGE SURVEYS.—Section 7451(d)(3) is amended by adding at the end the following new subparagraph:

''(F) The Under Secretary for Health shall provide appropriate education, training, and support to directors of Department health care facilities in the conduct and use of surveys, including the use of third-party surveys, under this paragraph.''.

(2) INFORMATION ON METHODOLOGY USED IN WAGE SURVEYS.—Section 7451(e)(4) is amended—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following new subparagraph (D):

''(D) In any case in which the director conducts such a wage survey during the period covered by the report and makes adjustment in rates of basic pay applicable to one or more covered positions at the facility, information on the methodology used in making such adjustment or adjustments.''.

(3) DISCLOSURE OF INFORMATION TO PERSONS IN COVERED POSITIONS.—Section 7451(e), as amended by paragraph (2) of this subsection, is further amended by adding at the end the following new paragraph:

''(6)(A) Upon the request of an individual described in subparagraph (B) for a report provided under paragraph (4) with respect to a Department health-care facility, the Under Secretary for Health or the director of such facility shall provide to the individual the most current report for such facility provided under such paragraph.

''(B) An individual described in this subparagraph is—

''(i) an individual in a covered position at a Department health-care facility; or

''(ii) a representative of the labor organization representing that individual who is designated by that individual to make the request.''.

(l) ELIGIBILITY OF PART-TIME NURSES FOR ADDITIONAL NURSE PAY.—

(1) IN GENERAL.—Section 7453 is amended—

(A) in subsection (a), by striking ''a nurse'' and inserting ''a full-time nurse or part-time nurse'';

(B) in subsection (b)—

(i) in the first sentence—

(I) by striking ''on a tour of duty'';

(II) by striking ''service on such tour'' and inserting ''such service''; and

(III) by striking ''of such tour'' and inserting ''of such service''; and

(ii) in the second sentence, by striking ''of such tour'' and inserting ''of such service'';

(C) in subsection (c)—

(i) by striking ''on a tour of duty''; and

(ii) by striking ''service on such tour'' and inserting ''such service''; and

(D) in subsection (e)—

(i) in paragraph (1), by striking ''eight hours in a day'' and inserting ''eight consecutive hours''; and

(ii) in paragraph (5)(A), by striking ''tour of duty'' and inserting ''period of service''.

(2) EXCLUSION OF APPLICATION OF ADDITIONAL NURSE PAY PROVISIONS TO CERTAIN ADDITIONAL EMPLOYEES.—Paragraph (3) of section 7454(b) is amended to read as follows:

''(3) Employees appointed under section 7408 of this title performing service on a tour of duty, any part of which is within the period commencing at midnight Friday and ending at midnight Sunday, shall receive additional pay in addition to the rate of basic pay provided such employees for each hour of service on such tour at a rate equal to 25 percent of such employee's hourly rate of basic pay.''.

(m) ENHANCED AUTHORITY TO INCREASE RATES OF BASIC PAY TO OBTAIN OR RETAIN SERVICES OF CERTAIN PERSONS.—Section 7455(c) is amended to read as follows:

''(c)(1) Subject to paragraph (2), the amount of any increase under subsection (a) in the minimum rate for any grade may not (except in the case of nurse anesthetists, licensed practical nurses, licensed vocational nurses, nursing positions otherwise covered by title 5, pharmacists, and licensed physical therapists) exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent.

''(2) No rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.''.

SEC. 602. LIMITATIONS ON OVERTIME DUTY, WEEKEND DUTY, AND ALTERNATIVE WORK SCHEDULES FOR NURSES.

(a) OVERTIME DUTY.—

(1) IN GENERAL.—Subchapter IV of chapter 74 is amended by adding at the end the following new section:

''§ 7459. Nursing staff: special rules for overtime duty

''(a) LIMITATION.—Except as provided in subsection (c), the Secretary may not require nursing staff to work more than 40 hours (or 24 hours if such staff is covered under section 7456 of this title) in an administrative work week or more than eight consecutive hours (or 12 hours if such staff is covered under section 7456 or 7456A of this title).

''(b) VOLUNTARY OVERTIME.—(1) Nursing staff may on a voluntary basis elect to work hours otherwise prohibited by subsection (a).

''(2) The refusal of nursing staff to work hours prohibited by subsection (a) shall not be grounds to discriminate (within the meaning of section 704(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e–3(a))) against the staff, dismissal or discharge of the staff, or any other adverse personnel action against the staff.

''(c) OVERTIME UNDER EMERGENCY CIRCUMSTANCES.—(1) Subject to paragraph (2), the Secretary may require nursing staff to work hours otherwise prohibited by subsection (a) if—

''(A) the work is a consequence of an emergency that could not have been reasonably anticipated;

''(B) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary;

''(C) the Secretary has exhausted all good faith, reasonable attempts to obtain voluntary workers;

''(D) the nurse staff have critical skills and expertise that are required for the work; and

''(E) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.

''(2) Nursing staff may not be required to work hours under this subsection after the requirement for a direct role by the staff in responding to medical needs resulting from the emergency ends.

''(d) NURSING STAFF DEFINED.—In this section, the term 'nursing staff' includes the following;

''(1) A registered nurse.

''(2) A licensed practical or vocational nurse.

''(3) A nurse assistant appointed under this chapter or title 5.

''(4) Any other nurse position designated by the Secretary for purposes of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7458 the following new item:

''7459. Nursing staff: special rules for overtime duty.''.

(b) WEEKEND DUTY.—Section 7456 is amended—

(1) by striking subsection (c); and

(2) by redesignating subsection (d) as subsection (c).

(c) ALTERNATE WORK SCHEDULES.—

(1) IN GENERAL.—Section 7456A(b)(1)(A) is amended by striking ''three regularly scheduled'' and all that follows through the period at the end and inserting ''six regularly scheduled 12-hour tours of duty within a 14-day period shall be considered for all purposes to have worked a full 80-hour pay period.''.

(2) CONFORMING AMENDMENTS.—Section 7456A(b) is amended—

(A) in the subsection heading, by striking ''36/40'' and inserting ''72/80'';

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''40-hour basic work week'' and inserting ''80-hour pay period'';

(ii) in subparagraph (B), by striking ''regularly scheduled 36-hour tour of duty within the work week'' and inserting ''scheduled 72-hour tour of duty within the bi-weekly pay period'';

(iii) in subparagraph (C)—

(I) in clause (i), by striking ''regularly scheduled 36-hour tour of duty within an administrative work week'' and inserting ''scheduled 72-hour tour of duty within an administrative pay period'';

(II) in clause (ii), by striking ''regularly''; and

(III) in clause (iii), by striking ''regularly scheduled 36-hour tour of duty work week'' and inserting ''scheduled 72-hour tour of duty pay period''; and

(iv) in subparagraph (D), by striking ''regularly''; and

(C) in paragraph (3), by striking ''regularly''.

SEC. 603. IMPROVEMENTS TO CERTAIN EDUCATIONAL ASSISTANCE PROGRAMS.

(a) REINSTATEMENT OF HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE SCHOLARSHIP PROGRAM.—

(1) IN GENERAL.—Section 7618 is amended by striking ''December 31, 1998'' and inserting ''December 31, 2014''.

(2) EXPANSION OF ELIGIBILITY REQUIREMENTS.—Section 7612(b)(2) is amended by striking ''(under section'' and all that follows through ''or vocational nurse.'' and inserting the following: ''as an appointee under paragraph (1) or (3) of section 7401 of this title.''.

(b) IMPROVEMENTS TO EDUCATION DEBT REDUCTION PROGRAM.—

(1) INCLUSION OF EMPLOYEE RETENTION AS PURPOSE OF PROGRAM.—Section 7681(a)(2) is amended by inserting ''and retention'' after ''recruitment'' the first time it appears.

(2) ELIGIBILITY.—Section 7682 is amended—

(A) in subsection (a)(1), by striking ''a recently appointed'' and inserting ''an''; and

(B) by striking subsection (c).

(c) LOAN REPAYMENT PROGRAM FOR CLINICAL RESEARCHERS FROM DISADVANTAGED BACKGROUNDS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs may, in consultation with the Secretary of Health and Human Services, utilize the authorities available in section 487E of the Public Health Service Act (42 U.S.C. 288–5) for the repayment of the principal and interest of educational loans of appropriately qualified health professionals who are from disadvantaged backgrounds in order to secure clinical research by such professionals for the Veterans Health Administration.

(2) LIMITATIONS.—The exercise by the Secretary of Veterans Affairs of the authorities referred to in paragraph (1) shall be subject to the conditions and limitations specified in paragraphs (2) and (3) of section 487E(a) of the Public Health Service Act (42 U.S.C. 288–5(a)(2) and (3)).

(3) FUNDING.—Amounts for the repayment of principal and interest of educational loans under this subsection shall be derived from amounts available to the Secretary of Veterans Affairs for the Veterans Health Administration for Medical Services.

SEC. 604. STANDARDS FOR APPOINTMENT AND PRACTICE OF PHYSICIANS IN DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) STANDARDS.—

(1) IN GENERAL.—Subchapter I of chapter 74 is amended by inserting after section 7402 the following new section:

''§ 7402A. Appointment and practice of physicians: standards

''(a) IN GENERAL.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to qualify for appointment in the Veterans Health Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The standards shall incorporate the requirements of this section.

''(b) DISCLOSURE OF CERTAIN INFORMATION BEFORE APPOINTMENT.—Each individual seeking appointment in the Veterans Health Administration in the position of physician shall do the following:

''(1) Provide the Secretary a full and complete explanation of the following:

''(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence.

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each investigation or disciplinary action taken against the individual relating to the individual's performance as a physician.

''(2) Provide the Secretary a written authorization that permits the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Secretary any information in the records of such State on the following:

''(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State.

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each medical malpractice judgment against the individual by the courts or administrative agencies or bodies of such State.

''(D) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State.

''(E) Any change in the status of the license to practice medicine issued the individual by such State, including any voluntary or nondisciplinary surrendering of such license by the individual.

''(F) Any open investigation of the individual by an administrative agency or body of such State, or any outstanding allegation against the individual before such an administrative agency or body.

''(G) Any written notification by the State to the individual of potential termination of a license for cause or otherwise.

''(c) DISCLOSURE OF CERTAIN INFORMATION FOLLOWING APPOINTMENT.—(1) Each individual appointed in the Veterans Health Administration in the position of physician after the date of the enactment of this section shall, as a condition of service under the appointment, disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(A) A judgment against the individual for medical malpractice or negligence.

''(B) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed under paragraph (1) or (2) of subsection (b).

''(C) Any disposition of or material change in a matter disclosed under paragraph (1) or (2) of subsection (b).

''(D) Any lawsuit, disciplinary action, or claim filed or undertaken after the date of the disclosures under subsection (b).

''(2) Each individual appointed in the Veterans Health Administration in the position of physician as of the date of the enactment of this section shall do the following:

''(A) Not later than the end of the 60-day period beginning on the date of the enactment of this section and as a condition of service under the appointment after the end of that period, submit the request and authorization described in subsection (b)(2).

''(B) Agree, as a condition of service under the appointment, to disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(i) A judgment against the individual for medical malpractice or negligence.

''(ii) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed pursuant to subparagraph (A) or under this subparagraph.

''(iii) Any disposition of or material change in a matter disclosed pursuant to subparagraph (A) or under this subparagraph.

''(3) Each individual appointed in the Veterans Health Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b)(2). The requirement of this paragraph is in addition to the requirements of paragraph (1) or (2), as applicable.

''(d) INVESTIGATION OF DISCLOSED MATTERS.—(1) The Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment in the Veterans Health Administration in the position of physician shall perform an investigation (in such manner as the standards required by this section shall specify) of each matter disclosed under subsection (b) with respect to the individual.

''(2) The Director of the Veterans Integrated Services Network in which an individual is appointed in the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (c) with respect to the individual.

''(3) The results of each investigation performed under this subsection shall be fully documented.

''(e) APPROVAL OF APPOINTMENTS BY DIRECTORS OF VISNS.—(1) An individual may not be appointed in the Veterans Health Administration in the position of physician without the approval of the Director of the Veterans Integrated Services Network in which the individual will first serve under the appointment, unless the medical center director and credentialing and privileging manager of the facility hiring the physician certify in writing that—

''(A) a full investigation was carried out in compliance with section 104 of this title; and

''(B) an investigation did not disclose any actions described in subsections (b), (c), and (d) of such section.

''(2) In approving the appointment under this subsection of an individual for whom any matters have been disclosed under subsection (b), a Director shall—

''(A) certify in writing the completion of the performance of the investigation under subsection (d)(1) of each such matter, including the results of such investigation; and

''(B) provide a written justification why any matters raised in the course of such investigation do not disqualify the individual from appointment.

''(f) ENROLLMENT OF PHYSICIANS WITH PRACTICE PRIVILEGES IN PROACTIVE DISCLOSURE SERVICE.—Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each physician extended such privileges in the Proactive Disclosure Service of the National Practitioner Data Bank.

''(g) ENCOURAGING HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—(1) The Secretary shall, for each performance contract with a Director of a Veterans Integrated Services Network (VISN), include in such contract a provision that encourages such director to hire physicians who are board eligible or board certified in the specialty in which the physicians will practice.

''(2) The Secretary may determine the nature and manner of the provision described in paragraph (1).''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7402 the following new item:

''7402A. Appointment and practice of physicians: standards.''.

(b) EFFECTIVE DATE AND APPLICABILITY.—

(1) EFFECTIVE DATE.—Except as provided in paragraphs (2) and (3), the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS TO PHYSICIANS PRACTICING ON EFFECTIVE DATE.—In the case of an individual appointed to the Veterans Health Administration in the position of physician as of the date of the enactment of this Act, the requirements of section 7402A(f) of title 38, United States Code, as added by subsection (a) of this section, shall take effect on the date that is 60 days after the date of the enactment of this Act.

(3) APPLICABILITY OF REQUIREMENTS RELATED TO HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—The requirement of section 7402A(g) of such title, as added by subsection (a), shall begin with the first cycle of performance contracts for directors of Veterans Integrated Services Networks beginning after the date of the enactment of this Act.

TITLE VII—HOMELESS VETERANS MATTERS

SEC. 701. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING ON CERTAIN MILITARY PROPERTY.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing that is located on qualifying property described in subsection (b).

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) QUALIFYING PROPERTY.—Qualifying property under the pilot program is property that—

(1) was part of a military installation that was closed in accordance with—

(A) decisions made as part of the 2005 round of defense base closure and realignment under the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note); and

(B) subchapter III of chapter 5 of title 40, United States Code; and

(2) the Secretary of Defense determines, after considering any redevelopment plans of any local redevelopment authority relating to such property, may be used to assist the homeless in accordance with such redevelopment plan.

(c) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) DURATION OF PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) VERY LOW INCOME DEFINED.—In this section, the term ''very low income'' has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 702. PILOT PROGRAM ON FINANCIAL SUPPORT OF ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING.

(a) ESTABLISHMENT OF PILOT PROGRAM.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) QUALIFYING PROPERTY.—Qualifying property under the pilot program is any property in the United States on which permanent housing is provided or afforded to formerly homeless veterans, as determined by the Secretary.

(c) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) DURATION OF PILOT PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) VERY LOW INCOME DEFINED.—In this section, the term ''very low income'' has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 703. PILOT PROGRAM ON FINANCIAL SUPPORT OF ENTITIES THAT PROVIDE OUTREACH TO INFORM CERTAIN VETERANS ABOUT PENSION BENEFITS.

(a) AUTHORITY TO MAKE GRANTS.—In addition to the outreach authority provided to the Secretary of Veterans Affairs by section 6303 of title 38, United States Code, the Secretary may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) for services to provide outreach to inform low-income and elderly veterans and their spouses who reside in rural areas of benefits for which they may be eligible under chapter 15 of such title.

(b) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(c) DURATION OF PILOT PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $1,275,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 704. ASSESSMENT OF PILOT PROGRAMS.

(a) PROGRESS REPORTS.—Not less than one year before the expiration of the authority to carry out a pilot program authorized by sections 501 through 503, the Secretary of Veterans Affairs shall submit to Congress a progress report on such pilot program.

(b) CONTENTS.—Each progress report submitted for a pilot program under subsection (a) shall include the following:

(1) The lessons learned by the Secretary of Veterans Affairs with respect to such pilot program that can be applied to other programs with similar purposes.

(2) The recommendations of the Secretary on whether to continue such pilot program.

(3) The number of veterans and dependents served by such pilot program.

(4) An assessment of the quality of service provided to veterans and dependents under such pilot program.

(5) The amount of funds provided to grant recipients under such pilot program.

(6) The names of organizations that have received grants under such pilot program.

TITLE VIII—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

SEC. 801. GENERAL AUTHORITIES ON ESTABLISHMENT OF CORPORATIONS.

(a) AUTHORIZATION OF MULTI-MEDICAL CENTER RESEARCH CORPORATIONS.—

(1) IN GENERAL.—Section 7361 is amended—

(A) by redesignating subsection (b) as subsection (e); and

(B) by inserting after subsection (a) the following new subsection (b):

''(b)(1) Subject to paragraph (2), a corporation established under this subchapter may facilitate the conduct of research, education, or both at more than one medical center. Such a corporation shall be known as a 'multi-medical center research corporation'.

''(2) The board of directors of a multi-medical center research corporation under this subsection shall include the official at each Department medical center concerned who is, or who carries out the responsibilities of, the medical center director of such center as specified in section 7363(a)(1)(A)(i) of this title.

''(3) In facilitating the conduct of research, education, or both at more than one Department medical center under this subchapter, a multi-medical center research corporation may administer receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned.''.

(2) EXPANSION OF EXISTING CORPORATIONS TO MULTI-MEDICAL CENTER RESEARCH CORPORATIONS.—Such section is further amended by adding at the end the following new subsection:

''(f) A corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter in accordance with subsection (b) if—

''(1) the board of directors of the corporation approves a resolution permitting facilitation by the corporation of the conduct of

research, education, or both at the other Department medical center or medical centers concerned; and

''(2) the Secretary approves the resolution of the corporation under paragraph (1).''.

(b) RESTATEMENT AND MODIFICATION OF AUTHORITIES ON APPLICABILITY OF STATE LAW.—

(1) IN GENERAL.—Section 7361, as amended by subsection (a) of this section, is further amended by inserting after subsection (b) the following new subsection (c):

''(c) Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State in which the applicable Department medical center is located and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State. In the case of any multi-medical center research corporation that facilitates the conduct of research, education, or both at Department medical centers located in different States, the corporation shall be established in accordance with the nonprofit corporation laws of the State in which one of such Department medical centers is located.''.

(2) CONFORMING AMENDMENT.—Section 7365 is repealed.

(c) CLARIFICATION OF STATUS OF CORPORATIONS.—Section 7361, as amended by this section, is further amended—

(1) in subsection (a), by striking the second sentence; and

(2) by inserting after subsection (c) the following new subsection (d):

''(d)(1) Except as otherwise provided in this subchapter or under regulations prescribed by the Secretary, any corporation established under this subchapter, and its officers, directors, and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives that apply generally to private nonprofit corporations.

''(2) A corporation under this subchapter is not—

''(A) owned or controlled by the United States; or

''(B) an agency or instrumentality of the United States.''.

(d) REINSTATEMENT OF REQUIREMENT FOR 501(C)(3) STATUS OF CORPORATIONS.—Subsection (e) of section 7361, as redesignated by subsection (a)(1) of this section, is further amended by inserting ''section 501(c)(3) of'' after ''exempt from taxation under''.

SEC. 802. CLARIFICATION OF PURPOSES OF CORPORATIONS.

(a) CLARIFICATION OF PURPOSES.—Subsection (a) of section 7362 is amended—

(1) in the first sentence—

(A) by striking ''Any corporation'' and all that follows through ''facilitate'' and inserting ''A corporation established under this subchapter shall be established to provide a flexible funding mechanism for the conduct of approved research and education at one or more Department medical centers and to facilitate functions related to the conduct of''; and

(B) by inserting before the period at the end the following: ''or centers''; and

(2) in the second sentence, by inserting ''or centers'' after ''at the medical center''.

(b) MODIFICATION OF DEFINED TERM RELATING TO EDUCATION AND TRAINING.—Subsection (b) of such section is amended in the matter preceding paragraph (1) by striking ''the term 'education and training' '' and inserting ''the term 'education' includes education and training and''.

(c) REPEAL OF ROLE OF CORPORATIONS WITH RESPECT TO FELLOWSHIPS.—Paragraph (1) of subsection (b) of such section is amended by striking the flush matter following subparagraph (C).

(d) AVAILABILITY OF EDUCATION FOR FAMILIES OF VETERAN PATIENTS.—Paragraph (2) of subsection (b) of such section is amended by striking ''to patients and to the families'' and inserting ''and includes education and training for patients and families''.

SEC. 803. MODIFICATION OF REQUIREMENTS FOR BOARDS OF DIRECTORS OF CORPORATIONS.

(a) REQUIREMENTS FOR DEPARTMENT BOARD MEMBERS.—Paragraph (1) of section 7363(a) is amended to read as follows:

''(1) with respect to the Department medical center—

''(A)(i) the director (or directors of each Department medical center, in the case of a multi-medical center research corporation);

''(ii) the chief of staff; and

''(iii) as appropriate for the activities of such corporation, the associate chief of staff for research and the associate chief of staff for education; or

''(B) in the case of a Department medical center at which one or more of the positions referred to in subparagraph (A) do not exist, the official or officials who are responsible for carrying out the responsibilities of such position or positions at the Department medical center; and''.

(b) REQUIREMENTS FOR NON-DEPARTMENT BOARD MEMBERS.—Paragraph (2) of such section is amended—

(1) by inserting ''not less than two'' before ''members''; and

(2) by striking ''and who'' and all that follows through the period at the end and inserting ''and who have backgrounds, or business, legal, financial, medical, or scientific expertise, of benefit to the operations of the corporation.''.

(c) CONFLICTS OF INTEREST.—Subsection (c) of section 7363 is amended by striking '', employed by, or have any other financial relationship with'' and inserting ''or employed by''.

SEC. 804. CLARIFICATION OF POWERS OF CORPORATIONS.

(a) IN GENERAL.—Section 7364 is amended to read as follows:

''§ 7364. General powers

''(a) IN GENERAL.—(1) A corporation established under this subchapter may, solely to carry out the purposes of this subchapter—

''(A) accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities;

''(B) enter into contracts and agreements with individuals and public and private entities;

''(C) subject to paragraph (2), set fees for education and training facilitated under section 7362 of this title, and receive, retain, administer, and spend funds in furtherance of such education and training;

''(D) reimburse amounts to the applicable appropriation account of the Department for the Office of General Counsel for any expenses of that Office in providing legal services attributable to research and education agreements under this subchapter; and

''(E) employ such employees as the corporation considers necessary for such purposes and fix the compensation of such employees.

''(2) Fees charged under paragraph (1)(C) for education and training described in that paragraph to individuals who are officers or employees of the Department may not be paid for by any funds appropriated to the Department.

''(3) Amounts reimbursed to the Office of General Counsel under paragraph (1)(D) shall be available for use by the Office of the General Counsel only for staff and training, and related travel, for the provision of legal services described in that paragraph and shall remain available for such use without fiscal year limitation.

''(b) TRANSFER AND ADMINISTRATION OF FUNDS.—(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or centers, other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purposes.

''(2) A Department medical center may reimburse the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 5.

''(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter. Such funds shall be credited to the applicable appropriation account of the Department and shall be available, without fiscal year limitation, for the purposes of that account.

''(c) RESEARCH PROJECTS.—Except for reasonable and usual preliminary costs for project planning before its approval, a corporation established under this subchapter may not spend funds for a research project unless the project is approved in accordance with procedures prescribed by the Under Secretary for Health for research carried out with Department funds. Such procedures shall include a scientific review process.

''(d) EDUCATION ACTIVITIES.—Except for reasonable and usual preliminary costs for activity planning before its approval, a corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

''(e) POLICIES AND PROCEDURES.—The Under Secretary for Health may prescribe policies and procedures to guide the spending of funds by corporations established under this subchapter that are consistent with the purpose of such corporations as flexible funding mechanisms and with Federal and State laws and regulations, and executive orders, circulars, and directives that apply generally to the receipt and expenditure of funds by nonprofit organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENT.—Section 7362(a), as amended by section 802(a)(1) of this Act, is further amended by striking the last sentence.

SEC. 805. REDESIGNATION OF SECTION 7364A OF TITLE 38, UNITED STATES CODE.

(a) REDESIGNATION.—Section 7364A is redesignated as section 7365.

(b) CLERICAL AMENDMENTS.—The table of sections at the beginning of chapter 73 is amended—

(1) by striking the item relating to section 7364A; and

(2) by striking the item relating to section 7365 and inserting the following new item:

''7365. Coverage of employees under certain Federal tort claims laws.''.

SEC. 806. IMPROVED ACCOUNTABILITY AND OVERSIGHT OF CORPORATIONS.

(a) ADDITIONAL INFORMATION IN ANNUAL REPORTS.—Subsection (b) of section 7366 is amended to read as follows:

''(b)(1) Each corporation shall submit to the Secretary each year a report providing a detailed statement of the operations, activities, and accomplishments of the corporation during that year.

''(2)(A) A corporation with revenues in excess of $300,000 for any year shall obtain an audit of the corporation for that year.

''(B) A corporation with annual revenues between $10,000 and $300,000 shall obtain an audit of the corporation at least once every three years.

''(C) Any audit under this paragraph shall be performed by an independent auditor.

''(3) The corporation shall include in each report to the Secretary under paragraph (1) the following:

''(A) The most recent audit of the corporation under paragraph (2).

''(B) The most recent Internal Revenue Service Form 990 'Return of Organization Exempt from Income Tax' or equivalent and the applicable schedules under such form.''.

(b) CONFIRMATION OF APPLICATION OF CONFLICT OF INTEREST REGULATIONS TO APPROPRIATE CORPORATION POSITIONS.—Subsection (c) of such section is amended—

(1) by striking ''laws and'' each place it appears;

(2) in paragraph (1)—

(A) by inserting ''each officer and'' after ''under this subchapter,''; and

(B) by striking '', and each employee of the Department'' and all that follows through ''during any year''; and

(3) in paragraph (2)—

(A) by inserting '', officer,'' after ''verifying that each director''; and

(B) by striking ''in the same manner'' and all that follows before the period at the end.

(c) ESTABLISHMENT OF APPROPRIATE PAYEE REPORTING THRESHOLD.—Subsection (d)(3)(C) of such section is amended by striking ''$35,000'' and inserting ''$50,000''.

TITLE IX—CONSTRUCTION AND NAMING MATTERS

SEC. 901. AUTHORIZATION OF MEDICAL FACILITY PROJECTS.

(a) AUTHORIZATION OF FISCAL YEAR 2010 MAJOR MEDICAL FACILITY PROJECTS.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, with each project to be carried out in the amount specified for each project:

(1) Construction (including acquisition of land) for the realignment of services and closure projects at the Department of Veterans Affairs Medical Center in Livermore, California, in an amount not to exceed $55,430,000.

(2) Construction of a Multi-Specialty Care Facility in Walla Walla, Washington, in an amount not to exceed $71,400,000.

(3) Construction (including acquisition of land) for a new medical facility at the Department of Veterans Affairs Medical Center in Louisville, Kentucky, in an amount not to exceed $75,000,000.

(4) Construction (including acquisition of land) for a clinical expansion for a Mental Health Facility at the Department of Veterans Affairs Medical Center in Dallas, Texas, in an amount not to exceed $15,640,000.

(5) Construction (including acquisition of land) for a replacement bed tower and clinical expansion at the Department of Veterans Affairs Medical Center in St. Louis, Missouri, in an amount not to exceed $43,340,000.

(b) EXTENSION OF AUTHORIZATION FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS PREVIOUSLY AUTHORIZED.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, as follows with each project to be carried out in the amount specified for that project:

(1) Replacement of the existing Department of Veterans Affairs Medical Center in Denver, Colorado, in an amount not to exceed $800,000,000.

(2) Construction of Outpatient and Inpatient Improvements in Bay Pines, Florida, in an amount not to exceed $194,400,000.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2010, or the year in which funds are appropriated, for the Construction, Major Projects account—

(A) $260,810,000 for the projects authorized in subsection (a); and

(B) $994,400,000 for the projects authorized in subsection (b).

(2) LIMITATION.—The projects authorized in subsections (a) and (b) may only be carried out using—

(A) funds appropriated for fiscal year 2010 pursuant to the authorization of appropriations in paragraph (1) of this section;

(B) funds available for Construction, Major Projects for a fiscal year before fiscal year 2010 that remain available for obligation;

(C) funds available for Construction, Major Projects for a fiscal year after fiscal year 2010 that remain available for obligation;

(D) funds appropriated for Construction, Major Projects for fiscal year 2010 for a category of activity not specific to a project;

(E) funds appropriated for Construction, Major Projects for a fiscal year before 2010 for a category of activity not specific to a project; and

(F) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project.

SEC. 902. DESIGNATION OF ROBLEY REX DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

(a) DESIGNATION.—The Department of Veterans Affairs Medical Center in Louisville, Kentucky, and any successor to such medical center, shall after the date of the enactment of this Act be known and designated as the ''Robley Rex Department of Veterans Affairs Medical Center''.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the medical center referred to in subsection (a) shall be considered to be a reference to the Robley Rex Department of Veterans Affairs Medical Center.

SEC. 903. MERRIL LUNDMAN DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC.

(a) IN GENERAL.—The Department of Veterans Affairs outpatient clinic in Havre, Montana, shall after the date of the enactment of this Act be known and designated as the ''Merril Lundman Department of Veterans Affairs Outpatient Clinic''.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the outpatient clinic referred to in subsection (a) shall be considered to be a reference to the Merril Lundman Department of Veterans Affairs Outpatient Clinic.

SEC. 904. MODIFICATION ON RESTRICTION OF ALIENATION OF CERTAIN REAL PROPERTY IN GULF PORT, MISSISSIPPI.

(a) IN GENERAL.—Section 2703(b) of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234; 120 Stat. 469), as amended by section 231 of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009 (division E of Public Law 110–329; 122 Stat. 3713), is further amended by inserting after ''the City of Gulfport'' the following: '', or its urban renewal agency,''.

(b) MEMORIALIZATION OF MODIFICATION.—The Secretary of Veterans Affairs shall take appropriate actions to modify the quitclaim deeds executed to effectuate the conveyance authorized by section 2703 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234) in order to accurately reflect and memorialize the amendment made by subsection (a).

TITLE X—OTHER MATTERS

SEC. 1001. EXPANSION OF AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 902 is amended—

(1) in subsection (a)—

(A) by amending paragraph (1) to read as follows:

''(1) Employees of the Department who are Department police officers shall, with respect to acts occurring on Department property—

''(A) enforce Federal laws;

''(B) enforce the rules prescribed under section 901 of this title;

''(C) enforce traffic and motor vehicle laws of a State or local government (by issuance of a citation for violation of such laws) within the jurisdiction of which such Department property is located as authorized by an express grant of authority under applicable State or local law;

''(D) carry the appropriate Department-issued weapons, including firearms, while off Department property in an official capacity or while in an official travel status;

''(E) conduct investigations, on and off Department property, of offenses that may have been committed on property under the original jurisdiction of Department, consistent with agreements or other consultation with affected local, State, or Federal law enforcement agencies; and

''(F) carry out, as needed and appropriate, the duties described in subparagraphs (A) through (E) of this paragraph when engaged in duties authorized by other Federal statutes.'';

(B) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2), as redesignated by subparagraph (B) of this paragraph, by inserting '', and on any arrest warrant issued by competent judicial authority'' before the period; and

(2) by amending subsection (c) to read as follows:

''(c) The powers granted to Department police officers designated under this section shall be exercised in accordance with guidelines approved by the Secretary and the Attorney General.''.

SEC. 1002. UNIFORM ALLOWANCE FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 903 is amended—

(1) by amending subsection (b) to read as follows:

''(b)(1) The amount of the allowance that the Secretary may pay under this section is the lesser of—

''(A) the amount currently allowed as prescribed by the Office of Personnel Management; or

''(B) estimated costs or actual costs as determined by periodic surveys conducted by the Department.

''(2) During any fiscal year no officer shall receive more for the purchase of a uniform described in subsection (a) than the amount established under this subsection.''; and

(2) by striking subsection (c) and inserting the following new subsection (c):

''(c) The allowance established under subsection (b) shall be paid at the beginning of a Department police officer's employment for those appointed on or after October 1, 2008. In the case of any other Department police officer, an allowance in the amount established under subsection (b) shall be paid upon the request of the officer.''.

Mrs. MURRAY. Madam President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Washington is recognized.

MORNING BUSINESS

Mrs. MURRAY. Madam President, I ask unanimous consent the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. MURRAY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. GRASSLEY. Madam President, we have been waiting for many weeks while the Democratic leadership worked behind closed doors to write a new health care reform bill. Rather than trying to build consensus for a bill that could get broad-based support, they toiled in secret, but at long last this new health care reform plan is finally public. They have come forward to at last reveal the legislative language for a health care reform bill that the Democrats intend to bring to the floor.

We know where they started. We know the changes they made along the way. Those in this Chamber will recall that we worked for months in the Senate Finance Committee on health reform. Senator BAUCUS and I worked very carefully in committee to try to develop a bipartisan reform plan.

Health care, as everybody knows, is one-sixth of the economy. If that economic fact is obscure to people, $1 out of every $6 in the United States is spent on health care.

We are, of course, to spend upward of $33 trillion on health care in this country over the next decade—$33 trillion. Already our health care system is on an unsustainable path. Our current health care entitlement programs, at least the two, Medicare and Medicaid, are both on very unsound financial footing. Not only are both programs in jeopardy financially, but the magnitude of the problem is a real threat to the Federal budget.

Starting in 2008, the Medicare Program began spending more out of the hospital insurance trust fund than it is taking in. That deficit spending at the trust fund is the beginning of the end of Medicare unless Congress steps in and does something to maintain that trust fund. The Medicare trustees have been warning us for years that the hospital insurance fund—the trust fund, that is—is going to go broke. They now predict that year of going broke is 2017. To keep Medicare going for future retirees means finding a way to bridge the gap for the $75 trillion of unfunded liability, and this must be done in a manner that does not worsen the health care quality or access for beneficiaries.

Likewise, the Medicaid Program, which serves 59 million low-income pregnant women as well as children and the families, is on a very shaky financial ground.

We have the Government Accountability Office reporting to Congress that States—meaning the 50 States—are reaching a crisis with their part of the Medicaid Program. The Government Accountability Office models predict that State spending will grow faster than State revenues for at least the next 10 years. The impact of declining revenues is very clear. I quote what the GAO has said about this situation:

> Since most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest that, without intervention, these governments would need to make substantial policy changes to avoid growing fiscal imbalances.

This, too, is the crisis facing the Medicaid Program today. So both of the two major Federal health care programs are in very serious trouble. These are major problems with some of the most significant implications for our entire country and the 300 or more million people who live here. If reforms to health care are not done carefully—and I say ''carefully'' because I am not saying they should not be done—this is going to make the situation far worse, not better. Anyone listening would have no doubt of the ability of Congress to make it worse.

These dire economic implications are not the only thing at stake with health care reform. Besides the significant economic implications of health care reform, this is a bill that affects everyone in another very important way. It affects everyone's health by changing the way we get health care in this country. It touches the lives of every family, every senior, every child, every student. In plain language, it affects everybody: the 306 million people who live here now and the many more people who will be living here in the future.

It makes changes to health care that will be nearly impossible to undo. The reforms these bills contemplate will make long lasting changes to our health care system. These are changes all of us will have to live with for decades to come. Health reform presents this Chamber with a bill that has significant economic implications at a time when all eyes are focused on the economy, so focused on the economy that it almost reminds me of how President Clinton got elected on the campaign slogan, ''It's the economy, stupid.'' This health care reform bill is a bill that will make permanent changes to our system of health care.

For all of these reasons, it makes it all the more important that changes of this magnitude be done with broad-based support in this Chamber and across the country. This broad-based support was something Senator BAUCUS and I focused on in our work on the Finance Committee, as we were trying to bring forth a bill that would be bipartisan.

In the Finance Committee, we believed strongly that a bill of such significance should be done with broad-based support; in other words, health care is a life-or-death issue for every American, and it affects $1 out of every $6 spent in America. Because it is so big, that is the basis for that statement ''broad-based support.''

Under the leadership of Senator BAUCUS, chairman of the Finance Committee, we started last year with a bipartisan health care reform summit. We held 20 hearings. We held three public forums this year on options for financing, coverage, and delivery system reform. We invited in experts from across the country. We invited anyone to submit input to the committee on those options, and we received over 600 sets of comments on the option papers.

Senator BAUCUS and I developed the broad outlines of what we believed would be a good reform package. That broad outline reflected the input we had from that very open and public process. We took that outline, and we sat down with four other leaders on the issue of health care in this very Chamber. That group soon became known as the group of six. That group began meeting in June to take that framework and finish the important details. We met for untold hours. We consulted with experts at the Congressional Budget Office and the Joint Committee on Taxation. We invested a tremendous amount of time and effort to develop a bipartisan package.

Then what happens around here too often? People get impatient. In this case, the Democratic leaders got impatient. They wanted the reform bill to be finished faster. They were more concerned with health care reform getting done right now rather than getting done right. We said we needed to give the process the time it needed. We said we were not going to be bound by arbitrary deadlines. We wanted to get the job done right. But when the first of September rolled around, they were not willing to give the group of six any more time.

As a result, the Democratic leaders pulled the plug on that bipartisan work, and the hope for a bill with broad bipartisan support ended at that point. Ultimately, the Finance Committee reported out a bill that did not have that broad bipartisan support, the support we had hoped for earlier in the year. The bigger and far more liberal agenda driven by the White House and the Democratic leadership went beyond where the true consensus on reform exists.

Now the next step in this process has been to merge together the bills from the HELP Committee and the Finance Committee. That job fell to the Democratic leader and the chairmen of the two committees. But, ultimately, their

leader even excluded the chairmen from the process. That process began on October 2. So the rest of the Senate has been waiting ever since that time to see what would emerge from behind closed doors just across the hall.

But then people started to complain about how long it was taking to develop the merged bill. When that happened, lo and behold, we started to hear from the Democratic leader what the group of six had been saying. That leader, too, started saying he was not going to be bound by any artificial timeline. He, too, started saying he was going to take whatever time he needed. Imagine our shock and dismay when we heard this. All the impatience we heard about how long our bipartisan process was taking, the criticism we took.

So they pulled the plug on that effort out of impatience. My suspicion is that only now is there a realization of how hard it is to assemble a comprehensive health care reform plan. Now at long last, that merged bill is before us. Now we know what is in it. The bill has undergone many changes since the Democrats decided to do a partisan bill. They are not positive. They have moved more and more to not only a partisan agenda, they have moved to an extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

Surely they don't expect 100 Senators to get this done faster than it took a leader behind closed doors to get the bill done, to put together the two bills between the Finance Committee and the HELP Committee, what we have before us or will eventually have before us. But it is not Republicans who are slowing this down. It is not because of Republicans that it took so long to merge these two Senate bills. It is not because of Republicans that it took the House so long after July to finally vote on the bill.

The reason for the difficulties is that their leftwing is driving the health reform agenda so far to the extreme left. It is so far to the left that they are having trouble getting everyone on their side to support that agenda? In the other body, 39 Democrats voted against Speaker PELOSI's plan, and you can be sure that we would have seen a bill in the Senate much sooner than now if all Democrats were lined up behind this effort.

But this is where we are. Now let's look at what has been produced, what changes have been made to produce the merged bill. I will highlight a few of the changes I find most disturbing. As I highlight these issues, it will be clear that this bill is already sliding rapidly down the slippery slope to more and more government control of health care. It still has the biggest expansion of Medicaid since the program was created in 1965. It still imposes an unprecedented and intrusive Federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service. It still increases the size of the government by $2.5 trillion when fully implemented. It has gotten even more expensive since the Finance Committee started. It still gives the Secretary of Health and Human Services the power to set prices and define benefits for private health plans. That is a lot of government power in Washington over people's lives. It still will cause health care premiums for millions to go up.

As I said when this process started, the bill released by the Finance Committee was an incomplete but comprehensive, good-faith attempt to reach bipartisan agreement. But ever since that moment, the bill has moved further and further away from that approach on several key issues. Now we can see clearly that the bill continues its march leftward. It continues to take shape into an extreme agenda driven by the far left. This far left partisan change is precisely what my party feared would occur at later stages in the legislative process.

Today we see these fears were legitimate and justified. Nevertheless, I still hold out hope that at some point the doorway for bipartisanship will again open. I hope at some point the White House and leadership will want to correct the mistakes they made by ending our collaborative, bipartisan work of 3 months during the summer. I hope at some point they will want to let that bipartisan work begin again. Then they need to back that effort and give it the time needed to get it right rather than getting it done right now. It is clear that today is not the day that is going to happen.

I yield the floor.

The PRESIDING OFFICER (Mrs. MCCASKILL). The Senator from Colorado.

Mr. BENNET. Madam President, I am pleased to be here today with my colleague from New Hampshire to talk about fiscal accountability in the context of the health care reform discussion we have been having.

Back in Colorado, people are not talking about far-left or far-right or Democratic or Republican. That is not what concerns them. What concerns them is that for the last 10 years they have seen double-digit increases in the cost of their health insurance, year-in and year-out, at a time, by the way, when their incomes actually declined.

Even before we were in the worst recession since the Great Depression—which we are in today—during the last recovery, the Bush recovery, it was the first recovery in the history of the United States when median family income actually declined. It was, in effect, for a working family a recession, and they are now having to recover not just from the greatest recession since the Great Depression but from a 10-year period when they actually fell behind in terms of their income. What was happening at the same time their income was going down? The cost of health insurance was going up, by 97 percent in my State. By the way, higher education was going up by 50 percent during this same period.

What we have said to working families before this recession and now in the depths of this recession is that they are expected to do more with less. They are threatened by politics in Washington that for decades has allowed special interests to get in the way of our passing meaningful health care reform for working families and small businesses. At the same time, we have tripled our Federal budget deficits and added to the national debt, as we have been unable to deliver for families all across the United States.

Well, today we are closer than ever to meaningful health care reform that lowers costs, reduces the Nation's long-term deficits, and improves access to quality, affordable care for Colorado's families. With the release of the Patient Protection and Affordable Care Act, we have taken a major step forward. This bill will help put our Nation back on a track to fiscal responsibility.

There is much more we need to do to get us where we need to be. I am the father of three little girls who are 10, 8, and 5, and I am desperate about the amount of debt we have loaded up on our Federal Government, about the size of our Federal budget deficit. While reforming health care is not sufficient to fix that problem, it is a very important step forward. Our Nation's annual deficits are enormous and our debt is staggering. Health care reform, as I said, must help solve that problem, not make it worse.

I, for one, have said from the very beginning of this debate that I would not support a health care reform bill that added a dollar to our deficit. I am very pleased to see that the bill the leader has produced does not do that.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help to solve the fiscal problems that threaten our economy and our kids' futures. Without reform, if we just hold on to the status quo, if we listen to the siren call of special interests, out-of-control health care costs will place an ever higher burden on government expenditures and create structural deficits that could persist for decades as a drag on economic recovery and growth, with deficits and debt for as far as our eyes can see.

Rising health care costs—especially Medicare costs—are the largest driver of our deficits. Our Nation's health care spending today is 17 percent of our gross domestic product. It is slated to grow to over 20 percent in the blink of an eye. Health care will soon account for one-fifth of our economy. That might not be such a big deal if every other industrialized country in the world was not devoting less than half of that as a percentage of their GDP to

health care. It is like having two small businesses, one across the street from the other, and one is spending a fifth of their revenue on their light bill and the one across the street is spending less than half that. You do not need an MBA to know which of those small businesses is going to be able to invest in their business plan and grow. If we expect to be able to compete in the global economy, we need to devote a smaller percentage of our GDP to health care.

Since 1970, every year for almost 40 years—year-in and year-out—Medicare spending per person has risen by over 8 percent a year and private insurance spending per person has risen by over 9 percent a year. We cannot expect reform to begin at the private or employer-based level. We must drive these costs down at the Federal level by reorienting our Medicare incentive structure.

The Congressional Budget Office Director, Doug Elmendorf, has said that the ''rising costs for health care represent the single greatest challenge to balancing the federal budget.'' If you are embracing the status quo, you are embracing skyrocketing deficits.

The White House Budget Director, Peter Orszag, agrees, saying:

The single most important thing—

''The single most important thing''—

we can do to put the nation on a sounder long-term fiscal footing is to reduce the rate of growth of health care costs. Period.

Meanwhile, the cost of health insurance is eating into family budgets faster and faster. About 20 years ago, the cost of an average family health care policy was $4,700 in Colorado, representing 12 percent of the average family's income. Today, an average family's health care policy costs roughly $12,000, amounting to 20 percent of the family's income, going, by 2016, if we do nothing, to 40 percent of their income.

Middle-class wages are not even close to keeping up with these rising insurance costs. In fact, median family income in this country fell by $300 as health care costs increased by 80 percent just while the last administration was in office.

Looking outside the confines of the budget context, health care reform will contribute significantly to economic growth. Health care reform will rein in skyrocketing health care costs and achieve close to $2 trillion of savings through the entire health care system—savings that will result in real economic gains to families and businesses. The Council of Economic Advisers estimates that slowing health care costs will increase gross domestic product by 2 percent in 2020 and by 8 percent in 2030.

After 8 years of irresponsible deficit spending, this legislation will be budget neutral and will put us on course to reduce the deficit over the long term. It is no wonder that people doubt this is actually happening because it has been so long since this body was actually able to do something that was deficit neutral. In this case, we are actually going to improve our deficit situation.

The Congressional Budget Office report confirms that the Senate bill is fiscally responsible and will reduce the deficit. Specifically, the report says the bill cuts the budget deficit by $130 billion over 10 years; cuts the budget deficit by $650 billion in the second decade; extends coverage to over 94 percent of Americans, including a 31 million-person reduction in the uninsured; costs $849 billion; and achieves almost $1 trillion in cost savings.

Just this week, a bipartisan group of more than 20 leading economists released a letter urging passage of meaningful health reform. The economists said our provisions to improve delivery system reform and slow the growth of health care costs ''will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing.''

The challenges facing our health care system are not new. They are old. But if we fail to act, they will surely get worse, meaning higher premiums, skyrocketing costs, and deeper instability for those Americans who have coverage.

Today, thanks to a lot of hard work from a lot of people, we are closer than ever to enacting solutions to these problems and getting a finished bill to President Obama's desk as soon as possible.

Now is the time for us to set aside the childish politics that put us here. Now is the time to ignore the siren song of special interests. Now is the time for us to create a meaningful health care reform for working families and small businesses all across the United States.

Madam President, I yield the floor and look forward to hearing the remarks of my colleague from New Hampshire.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Thank you very much, Madam President.

I rise to join my colleague, Senator BENNET from Colorado, to express my strong support for moving forward to consider the Patient Protection and Affordable Care Act.

My office has responded to thousands of letters and phone calls about health care since we began this debate. I have traveled all across my home State of New Hampshire, talked to small business owners, talked to families who are desperate for help and to health care providers who are frustrated with our current system. Time and time again, what we have heard is that our health care system is not working. Costs are too high. Access is too limited. The status quo is not sustainable.

Now is the time to act. To put it very simply, our health care system is too expensive for families, for workers, for business owners, and for our Nation's economy. I think Senator BENNET laid out very clearly why, if we are going to be fiscally responsible, we have to address health care reform now. It is critical for the Senate to act.

I thank Majority Leader REID and Senators BAUCUS, DODD, and HARKIN, who have led the effort to bring forward the Patient Protection and Affordable Care Act. This is a very good starting point, and contrary to what we have heard, it incorporates many of the changes that have been offered by our Republican colleagues over these past months we have been working on health care.

This bill will help ensure Americans have greater access to quality affordable health care, and it will help begin the transformation within the health care system that is necessary if we are going to contain costs to accomplish the fiscal improvements Senator BENNET talked about.

I think particularly important is the fact that the Patient Protection and Affordable Care Act is fully paid for, so it will not increase the deficit one dime. In fact, by eliminating waste, fraud, and inefficiencies, by doing a more cost-effective job of providing health care, the bill is projected to reduce the deficit by almost $130 billion over the next 10 years. That is what I want to talk about this afternoon—some of those ways in which we can provide health care more cost-effectively and also improve health outcomes for people.

Research shows us that spending on health care does not necessarily translate into better health care. I am proud of the Dartmouth Institute for Health Policy, which is in my home State of New Hampshire, because it has been leading the way on some of this important research. What Dartmouth's research shows us is that when patients are engaged in their treatment decisions, they will choose the less invasive and less costly procedures 40 percent of the time. So almost half of the time, we know patients, when they are involved, are going to choose the less costly procedures—not only that, they are going to be happier about those treatment decisions. We know, based on this research, that the health care system can do better in so many cases for less and that we can recoup savings in our system.

One example of that, which I have worked hard on, along with Senator COLLINS from Maine, is something we call the Medicare Transitional Care Act. Experts estimate that we can save $5,000 per Medicare beneficiary if we can reduce costly readmissions. That is what our work shows. Medicare costs can be reduced and we can offer better support and coordination of care to Medicare patients if we keep seniors who are discharged from the hospital from unnecessarily returning. We know that 30 percent of seniors who are discharged from the hospital, who are on Medicare, are going to get readmitted within 90 days because we do not do a

good job of providing for that transition. If we add a benefit through Medicare that helps with that transition, we have a commonsense solution that will improve the quality of health care for our seniors and save taxpayers money. I am very pleased that this provision is included in the health care bill that is before us now or that we hope will be before us soon.

We can also contain health care costs by improving access to lower cost generic drugs. Again, that is something that is in the health care reform bill we are going to be considering. It gives people access to those lower cost generic drugs in a way that saves, generally, anywhere from 25 to 35 percent for generic drugs. It also sets up a process to give people access to lower cost biologic drugs—something we do not yet have, the ability to set up a process to give people access to generic biologics. So that is going to be able to save people money.

This legislation we hope to be able to work on will help Americans access lower cost medications. It will save taxpayers money. This is our opportunity to improve the quality of care available to Americans and to control costs at the same time. It is critical we achieve this for the citizens of New Hampshire and for all Americans. The Patient Protection and Affordable Care Act is a very important step forward. I hope all my colleagues will, as we debate this bill, look at the important changes we are making and decide this is our opportunity to get real, meaningful health care reform done.

Thank you, and I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri is recognized.

SEPTEMBER 11 TERRORISTS' TRIALS

Mr. BOND. Madam President, faith has written many painful chapters in America's history. Each is sharply engraved in our memories. Many involve military conflict: the British burning of Washington, the Civil War, Pearl Harbor, Iwo Jima, Pork Chop Hill.

Others were singular acts of aggression, such as the bombing of the Oklahoma City Federal Building, the assassinations of Martin Luther King and Presidents Lincoln, McKinley, and Kennedy.

September 11, 2001, is the latest painful chapter in American history, one that forever will be burned into our memories as a day of horror unlike any we have experienced before. The sheer magnitude and deliberate evil of the attacks that day defy comprehension. Who among us will soon forget the wrenching images of passenger planes used as missiles aimed at the World Trade Center Towers and the Pentagon or the people diving out of 70-story windows to avoid being burned again, and the heroic and selfless final acts of passengers aboard Flight 93 as it headed toward the Nation's Capital? Who among us will forget the pictures and the hopeful messages that sprang up around the area where the World Trade Center once proudly stood as relatives searched in vain for loved ones?

Three thousand men and women perished that day at the hands of terrorists who cared nothing for the innocent lives they stole. As the towers fell, their comrades and sympathizers, including Khalid Shaikh Mohammed, diabolically cheered the devastation.

It is these memories of 9/11 that make last week's decision by the Obama Justice Department to give the mastermind of these attacks and his associates all the rights and benefits of a civilian trial in New York City unexplainable and compel me to rise to voice my strong objection to that decision.

It is an insult to the memories of those who were brutally murdered on September 11 that the perpetrator of these cowardly acts will sit in a courtroom blocks away from Ground Zero and reap the full benefits and protections of the U.S. Constitution. Even worse than the insult to the victims and their families is the dangerous precipice the Obama Justice Department has now crossed with this foolhardy decision. Earlier this year, the Homeland Security Secretary signaled an alarming change of perspective about the nature of the enemy we face. No longer would we call the acts of terrorism what they are: acts of war. Instead, according to Secretary Napolitano, the accepted terminology for an attack such as 9/11 would now be a ''man-caused disaster.'' Apparently, 9/11 was no different than a forest fire started by an arsonist.

This initial change in terminology was troubling enough, but trying Khalid Shaikh Mohammed and his 9/11 associates in civilian Federal court sends a loud and clear signal that this administration is now comfortable recasting certain acts of terrorism as simply what the Attorney General calls ''extraordinary crimes.'' I have to wonder if the Attorney General thinks Pearl Harbor was an extraordinary crime. In the logic of this administration, murdering 3,000 civilians, including servicemembers at the Pentagon, is an extraordinary crime, justifying trial in a civilian court. Yet killing 17 servicemembers aboard the USS Cole is an act of war or the murder of 13 servicemembers at Fort Hood justifies continued proceedings before the military commissions. This arbitrary distinction makes no sense and shows a disturbing lack of understanding of the nature of this war.

It also creates a perverse incentive for terrorists to attack civilians so they may benefit from our treasured constitutional protections. KSM understood the benefits of these protections when, as former CIA Director George Tenet has said, KSM defiantly told CIA interrogators after his capture: ''I'll talk to you guys after I get to New York and see my lawyer.'' He was counting on going to New York to get the protections of our Constitution.

Words are simply words, but the mentality that these words represent is dangerously naive. Whether it is called a man-caused disaster or extraordinary crime, refusing to treat the September 11 perpetrators as terrorists, deserving only of a trial before a military commission, is a dangerous throwback to the pre-9/11 mentality that resulted in the attack on the USS Cole, the bombings of our embassies, and the first World Trade Center bombing.

Ordinarily, I support the concept of prosecutorial discretion and the right of the executive branch to bring criminal actions against perpetrators as supported by the facts. But in this instance, this discretion must give way to the larger national security interests of our country. In spite of the stated intention of KSM to plead guilty in the military commission, the Attorney General has asserted he believes there is a greater chance of success against these 9/11 coconspirators in civilian court. This belief—one I do not share—does not justify the enhanced risks to our security and the dangerous precedent for the treatment of future terrorists this trial will bring.

That this case will establish a very bad precedent was made clear by the Attorney General in his testimony before the Senate Judiciary Committee, when he summarily dismissed concerns that the decision to bring 9/11 coconspirators into the Federal justice system would preclude an intelligence community interrogation of Osama bin Laden if he were captured. The Attorney General refused to say whether bin Laden would be given Miranda warnings upon capture and claimed ''the case against him is so overwhelming'' that there would be no need to rely on any statements he might make after capture. Mr. Holder called the concerns about not being able to interrogate bin Laden a ''red herring.'' Well, unfortunately, the Attorney General's testimony shows a complete lack of understanding that the purpose of intelligence interrogations is to stop planned attacks and to take down terrorist networks, not to elicit confessions for use in a criminal trial.

It is beyond troubling that the Attorney General, as the head of the Department of Justice, the Justice Department's FBI National Security Division—the very people charged with preventing terrorist attacks, such as those disrupted in New York, Illinois, and North Carolina, seem to have no interest in obtaining valuable intelligence from bin Laden. As the leader of al-Qaida, bin Laden clearly has considerable knowledge of its network, its members, its methods, and its potential plots to kill more Americans. So what the Attorney General calls a red herring, I call a red flag.

Some have hailed the administration's decision as a way to showcase our judicial system for the world, but the Attorney General has confirmed that in the event KSM or one of his associates is acquitted, he will still be

detained indefinitely. Are you sure, Mr. Attorney General, that a court will not order him released?

This begs the question: Why should we incur the time, expense, and risk our national security on a show trial if we are just going to detain these terrorists forever anyway? Rather than showcasing our judicial system, this strange logic seems to make a mockery of the civilian judicial system. While the Attorney General has declared that failure is not an option, he does not control judicial rulings, nor the facts and perceptions that may sway any one of 12 jurors who will decide KSM's fate. A conviction will be expected, but there can be no guarantees.

Make no mistake, America is still at war. The war on terror is real. It will not go away just by calling it another name. We cannot afford to bury our heads in the sand. While Khalid Shaikh Mohammed may ultimately be convicted, our success in the war against terror will only be final when we have hunted these terrorists into extinction. We need look no further than the terror plots disrupted earlier this fall in New York, Colorado, Illinois, and at Quantico, to name a few, to understand the threats we faced on September 11 are still very real. For the men and women massacred in cold blood at Fort Hood, the ongoing threat of terrorism is all too real.

The Obama administration is standing at a crossroads of history. It can either persist in downplaying the reality that we are at war with terrorists or it can affirm that its top priority is to keep Americans safe by winning this war on terror.

Madam President, success in this war on terror cannot simply be defined as getting a guilty verdict against KSM in a civilian Federal court. If the Department of Justice jeopardizes our intelligence sources and methods, incurs unnecessary security risks, and creates a high-profile public platform for KSM to spew his hatred and espouse hirabah, they will only increase the likelihood that these detainees will proselytize fellow inmates in Federal prisons and convert followers worldwide. That is not success; that is failure of the worst kind—an avoidable failure.

These are not the hypothetical gambles that some on the left have dismissed casually. As former Attorney General Michael Mukasey, who presided as a judge over one of the trials, has stated, we know these domestic terror trials have exposed sensitive classified information and given important intelligence information to al-Qaida, allowing them to go undetected in more ways than they need.

A few examples:

The east Africa Embassy bombing trials made Osama bin Laden aware that cell phones were being intercepted, prompting al-Qaida to alter its methods of communication.

The trial of the World Trade Center bomber, Ramzi Yousef, tipped off terrorists to a communications link that provided ''enormously valuable intelligence,'' but was ''shut down'' after the disclosure.

Within days of being provided to the defense in the Omar Abdel-Rahman trial, the blind shaikh, a list of unindicted coconspirators, including Osama bin Laden, was provided to bin Laden.

During the trial of Zacarias Moussaoui, 48 classified documents—reports of FBI interviews with witnesses—were inadvertently provided to Moussaoui as part of the government's pretrial discovery response. In ordering the U.S. Marshals to seize the documents from Moussaoui's cell, the judge noted that ''significant national security interests of the United States could be compromised if the defendant were to retain copies of this classified information.''

I believe these examples provide ample evidence that public trials of these types of terrorism cases are a clear win for terrorists seeking to learn more about our intelligence sources and methods.

Were there no alternatives, we would proceed with this type of trial, despite the risk, because our Nation values due process. However, the military commissions process, first approved by Congress in 2006, and again last month, ensures a fair trial with rights to counsel, discovery, and appeal, but without the costs and risks of Federal civilian trials.

The concept of military commissions is one our Nation has relied upon before. When Congress created the military commissions process after September 11, it established a framework to ensure that intelligence sources and methods would not be jeopardized. While changes have been made over the years to the process itself in light of Supreme Court decisions, the general framework and principles remain solidly in place.

This process isn't new to this administration either. The administration is not only using this process, the Attorney General announced that the USS *Cole* bomber will still be tried under the commission. They worked with Congress to make the changes to it themselves.

Yet in the case of the 9/11 conspirators, the administration has chosen to reject the tried and true method of prosecuting enemy combatants in a venue where intelligence sources and methods are unlikely to be compromised in favor of circuses that will make the trial of Zacarias Moussaoui, with its endless motions and Moussaoui's challenge of a duel to former Attorney General Ashcroft, seem like a mundane proceeding.

This is an unnecessarily dangerous gamble. While the decision to take this gamble with our national security is clearly a matter for the executive branch, the administration has found a willing ally in many of my colleagues in Congress. Earlier this month, I joined 44 other Senators, from both sides of the aisle, in supporting an amendment to prohibit taxpayer funds from being used to prosecute in a civilian court the 9/11 perpetrators. Unfortunately, we were outvoted. The amendment didn't pass.

I encourage my colleagues to rethink their opposition. When the appropriate time comes, I hope they will reaffirm that our national security interests must have priority over politically correct prosecutions.

America is rightfully a different nation today than it was before September 11. We were attacked in a way and at a magnitude that we hope never to experience again. But we simply cannot rely on hope alone. Following these terrorist attacks, we took critical steps to try to ensure we are never attacked like this again. We made sure that we gave our intelligence professionals the tools they needed to fight terrorists, not just criminals. We gave them the tools they needed to fight a war and keep America safe.

We must always remember the lessons of September 11. We owe it to the victims of these and other terrorist attacks to keep our Nation safe. I call on the President from this floor to reverse this disastrous decision by the Attorney General and reaffirm his commitment to our national security and to winning this war against terrorism.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Madam President, I apologize to the Republican leader. I was detained in my office talking to another Senator, so I apologize for not being here and his having to wait.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. REID. Madam President, I ask unanimous consent that on Friday, November 20, at 10 a.m., the Senate proceed to a period of debate on the motion to proceed to H.R. 3590, until 11 p.m., with the time controlled in alternating 1-hour blocks, with the majority controlling the first hour; and at 10 p.m., Friday, there be 30-minute blocks until 11 p.m., with the majority controlling the first 30 minutes; further, that on Saturday, November 21, at 10 a.m., the Senate continue with controlled debate in alternating blocks until 6 p.m., with the majority controlling the first hour block; that at 6 p.m., the majority control the time until 6:30 p.m., the Republicans then control 6:30 to 7:15 p.m., the majority control 7:15 p.m. to 7:30 p.m., the Republican leader controls 7:30 to 7:45, and the majority leader controls 7:45 to 8 p.m.; that at 8 p.m., the Senate proceed to vote on the motion to invoke cloture on the motion to proceed to H.R. 3590; that if cloture is invoked on the motion, then all postcloture time be yielded back, the motion to proceed be agreed to, and the motion to reconsider be laid upon the table; that after the bill is reported, the majority leader be recognized to

call up his amendment and that it be reported by number only.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

CLOTURE MOTION

Mr. REID. Madam President, I move to proceed to Calendar No. 175, H.R. 3590, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to Calendar No. 175, H.R. 3590.

Harry Reid, Tom Harkin, Jack Reed, Edward E. Kaufman, Jeff Merkley, Roland W. Burris, Daniel K. Akaka, Patty Murray, Richard Durbin, Sherrod Brown, Michael F. Bennet, Jeanne Shaheen, Sheldon Whitehouse, Bill Nelson, Mark Udall, Benjamin L. Cardin, Christopher J. Dodd, Patty Murray.

Mr. REID. I ask that the mandatory quorum required under rule XXII be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. FRANKEN. Madam President, I ask unanimous consent that I be allowed to speak in morning business for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

COBRA SUBSIDY EXTENSION AND ENHANCEMENT ACT

Mr. FRANKEN. Madam President, I rise today to urge my colleagues to support S. 2730, the COBRA Subsidy Extension and Enhancement Act.

As you may know, COBRA allows jobless workers to keep their health care as they look for new work. The Recovery Act included a COBRA subsidy through the end of this year, but if we fail to act, millions of Americans currently looking for work will be faced with a further unbearable burden—the tripling of their COBRA payments.

I am very pleased with the Senate Patient Protection and Affordable Care Act that was released yesterday. This bill will help bring down health care costs for families and the Federal Government. We will invest in prevention and provide incentives to doctors to provide high-quality health care. I commend Leader REID, Chairman HARKIN, Chairman BAUCUS, and Chairman DODD for moving us one critical step closer to secure, affordable health care for all Americans. But while health care reform will bring long-term relief, the proposed COBRA extension will help us bridge the gap before health care reform is fully implemented.

Take, for example, the situation of one of my constituents, Gregory, from Lakeville, MN, southeast of the Twin Cities. Gregory has built a professional career in the printing industry, the same industry my dad was in. He was a printing salesman for 30 years. The printing industry has been especially hard hit by our current recession. Gregory's wife depends on him for health insurance. She has rheumatoid arthritis. My mom had rheumatoid arthritis. Gregory also has two daughters in school.

Gregory was laid off this March and has been tirelessly looking for a job ever since. But there aren't any jobs to be found. Now he has accepted that he may have to change fields, but he is 57 years old. A career change at 57 isn't easy. Unless Congress passes a COBRA extension, his premiums will nearly triple, going from $350 a month to $940 a month. In today's dismal economy, who has $940 each month to spend on health care insurance, especially if you don't have a job?

Gregory has explored the option of a private insurance plan, but his wife's preexisting rheumatoid arthritis makes private plans an impossibility. Gregory is hopeful, as am I, that passing a health care reform bill will eliminate this problem of preexisting conditions. But in the meantime, what are families like Gregory's supposed to do?

Gregory's family is not alone in this plight. CBO estimates that 7 million workers and their families have used the COBRA subsidies in 2009. That includes thousands and thousands of Minnesotans. The expiration of the subsidy will make premiums so expensive that many families will be forced to drop their coverage, adding further to the number of uninsured Americans. Now is not the time to put another burden on struggling families.

The COBRA Subsidy Extension and Enhancement Act will provide relief to families by extending the COBRA subsidy another 6 months, through June of 2010. By that time, our economy will have made significant progress in job creation, and many Americans will be back on the job. The extension will also include an increase in the subsidy—from 65 percent to 75 percent—allowing more families to retain coverage. During this recession, the last thing Congress should do is pull the plug on benefits before folks have had a chance to get back on their feet.

I know my colleagues Senators BROWN and CASEY share the same goal of passing meaningful health care reform this year. But they also know the importance of providing a stopgap measure to deliver relief to families who are struggling in the current downturn. I thank them for their leadership on these critical issues.

I urge my colleagues to swiftly enact the COBRA Subsidy Extension and Enhancement Act and allow more families to maintain health care insurance coverage as they look for work.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

APPROPRIATIONS BILLS

Mr. COCHRAN. Madam President, in the coming weeks and months, the Senate is scheduled to complete action on bills that will have a profound impact on Federal spending for many years to come. I rise to express my concerns about the manner in which new spending is being proposed in that legislation.

Congress has sent 5 of the 12 annual appropriations bills to the President for his signature. Four other bills are in conference with the House. The Senate has not yet acted upon the three remaining bills under our jurisdiction.

Last year, Congress completely abandoned the appropriations process. The year before that, only a few bills were acted upon by the Senate before all of the bills but one were bundled into an omnibus bill and sent to the President.

Thus far this year, we have not been able to complete action on all 12 appropriations bills, but we have made significant progress. The Senate has debated a stand-alone Agriculture appropriations bill and an Interior appropriations bill for the first time in 4 years. Ideally, these bills should be subjected to the scrutiny of the full Senate every year. This year, there have been hearings in each subcommittee, and the bills have been subjected to subcommittee and full committee markups. We have tried to get the bills to the floor individually so all Senators have an opportunity to offer amendments, and so we can avoid the necessity of grouping the bills into an omnibus bill.

The chairman, who is the distinguished Senator from Hawaii, Mr. INOUYE, deserves the credit for these improvements. All Senators on the committee have cooperated, though.

Despite the many difficulties associated with enacting the appropriations bills, the process compels us to hear testimony, analyze programs, and consider funding needs and priorities on an annual basis. It is not always a smooth or easy process, but it has the benefit of compelling us to continually reevaluate the level of Federal spending. That is not the case when we create long-term or permanent mandatory spending programs.

I don't mean to criticize the oversight of the authorizing committees. Many of them do excellent work in this regard, holding agencies and funding recipients accountable for their management decisions. But once a funding stream is made mandatory, it is difficult to reduce or cut off the spending or to use the leverage of future funding to motivate more efficient management of Federal programs or activities.

One of the justifications often cited for creating mandatory spending programs is that the funding recipients need predictability to properly and efficiently manage programs. While there may be some truth to this, in itself it is not a sufficient reason to make a new program mandatory or to change an existing program from discretionary to mandatory.

If increased predictability is the goal, Congress should make greater efforts to get the annual appropriations bills done as close to on time as possible and in an open and orderly fashion that allows scrutiny of the proposed spending.

Failure to process the appropriations bills in this manner has the effect of driving interest groups to seek the predictability of long-term mandatory funding streams. In effect, we create a situation whereby Congress must take proactive steps to reduce or eliminate spending as opposed to proactive steps to continue spending.

As a general matter, we should be very careful about moving programs in that direction, in my opinion. As I look at the major legislation that Congress is slated to consider over the coming months, I am greatly concerned. Of most immediate concern is the health care bill on which we will soon begin debate.

The bill reported by the Senate Finance Committee creates new programs with direct appropriations that should be funded or not funded through the annual appropriations process. There are mandatory programs for maternal, infant, and early childhood home visitation and for personal responsibility education for adulthood training. There are grants for school-based health centers, a demonstration program for emergency psychiatric care, and a demonstration program to address the health profession's workforce needs.

A previously authorized childhood obesity program is directly funded with a mandatory appropriation. Many of these programs are funded for only a few years, just enough time to get funding recipients invested in the program, after which expectations will be overwhelming that the programs be continued with annual appropriations.

As ranking member on the Labor, Health and Human Services Subcommittee, I might be inclined to support funding some of them, but beginning new programs with short-term, mandatory funding is a recipe for trouble. It results in hiding the long-term costs of these programs and provides no opportunity upfront to consider tradeoffs between the new programs and existing programs.

The health care bill reported by the HELP Committee includes a new prevention and public health fund to support an ''expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.'' That is a quote from the bill. The bill appropriates $2 billion for this purpose in fiscal year 2010 alone and increases that amount to $10 billion by fiscal year 2014 and thereafter.

This has long been a priority of the Senator from Iowa, Mr. HARKIN. To the committee's credit, the bill provides some latitude for the Appropriations Committee to allocate funds among various prevention and wellness programs in the outyears.

At its heart, however, this provision implies that we know today what the appropriate Federal investment for wellness programs will be 10 or 20 years from now. I just don't think that is plausible. If prevention and wellness programs are that important, let's call up the Labor, Health and Human Services appropriations bill and either increase the size of the bill or reallocate money within the bill to support wellness programs. When the fiscal year 2011 appropriations process begins, let's analyze how those programs are working and consider, once again, the appropriate funding levels for the coming year.

Beyond the health care bill, there is legislation to address global climate change. Here, again, we face the prospect of massive new annual Federal expenditures being established on a mandatory basis, effectively being put on autopilot right from the beginning. While nobody knows the value of the carbon allowances that would be auctioned under some climate bills, it is clear that tens of billions of dollars from such auctions would be plowed directly back into an array of programs administered by Federal, State, and local government agencies.

Some of the programs have a more obvious relationship to climate change than others. Just to list a few, the Senate-reported bill directly funds clean vehicle technology, building retrofits, advanced energy research, nuclear worker training, coastal preservation, and Federal land acquisition.

Many programs that would be funded by this bill are identical or similar to programs already funded in annual appropriations bills. Others are entirely new.

Are we truly confident in the year 2016 it will be prudent to spend 4.3 percent of an unknowable amount of auction revenues on international deforestation efforts? Are we sure that in the year 2030 we should be spending .74 percent of auction proceeds on worker assistance programs?

Congress should protect its ability to reconsider support or opposition to such spending annually, or at least periodically, based on program performance and our current national interests.

What about funding of Federal land acquisition? I have supported some Federal land acquisitions in my State of Mississippi, sometimes to incorporate important resources into our National Park System, sometimes to preserve sensitive habitats by including them in our national wildlife refuge system or in our national forests. I have had other Senators request specifically that we not approve the Federal acquisition of a particular piece of property. This has been a particularly sensitive issue for our western colleagues, particularly in whose States Federal land ownership is already extensive. Yet in the climate bill, we are being asked to allocate funding to the executive branch on a long-term basis for unspecified Federal land acquisition projects, all with no apparent mechanism for congressional oversight.

Are any Senators really comfortable with that arrangement? This is just one example of why Congress should consider programs on an annual basis through an open process rather than putting programs on autopilot and then struggling against the tide of entrenched interests to react when things do not go as expected.

In July, the House passed an education bill, the Student Aid and Fiscal Responsibility Act. The bill terminates the programs that authorized private lenders to make federally guaranteed loans to students and provides that future student loans will be provided only through direct Federal loans from the U.S. Department of Education.

My concern with this is that the House-passed bill establishes a number of new mandatory education programs and expands several existing programs with mandatory funding streams. The Congressional Budget Office estimates the House-passed bill would reduce mandatory spending by $87 billion over the next decade. But the House bill directly spends all but $8 billion of that amount on new and expanded programs. It directly funds a new college access and completion innovation fund. It establishes mandatory funding streams for school modernization, renovation, and repair, including a program of supplemental grants for States along the gulf coast. It establishes mandatory programs for early childhood education and for reforming community colleges and improving training for workforce development.

In many cases, these are new programs. In some cases, the mandatory amounts are meant to supplement funding currently provided through annual appropriations.

Regardless of the merits of these programs, the fact remains that we are faced with a debt problem of huge proportions. We have now closed the books on fiscal year 2009, finishing the year with a budget deficit of $1.4 trillion. We began fiscal year 2010 with a deficit of $176 billion for the month of October. Our national debt has hit $12 trillion, and soon Congress will have to act to raise the Federal debt ceiling again.

President Obama's own budget, optimistic in many respects, forecasts that our national debt will be rising to 66 percent of the gross domestic product by 2013. The Congressional Budget Office forecasts debt reaching 87 percent

of GDP in 2020 and increasing thereafter to even more alarming levels.

Given this set of facts, is it responsible to enact a bill that is expected to produce—not guaranteed to produce but expected to produce—a savings of $87 billion in mandatory spending but then in the same legislation spends all but $8 billion of that anticipated savings on new programs or expansions of existing programs that could just as well be achieved through the annual appropriations process?

Is it responsible to advance a climate bill that spends tens of billions of dollars on new mandatory programs and to allocate funding among those programs for decades into the future when we have no ability to judge whether those programs are needed or effective or what different programs might be necessary depending on how climate legislation would affect our economy, our workforce, and our environment?

Can we afford to enact a health care bill that is long on new costly mandatory programs but short on cost savings that we all know must be found within our health care system?

Certainly, there are situations where mandatory funding is an appropriate mechanism to deliver government services. In cases where our goal is to provide a service to a certain group of eligible people, regardless of how many people may be eligible in a given year, a mandatory appropriation may be the most efficient means of achieving that goal.

Given our Nation's fiscal situation, however, it seems to me we should strongly favor a procedure that requires Congress to consider programmatic spending every year. This is the very principle stated in paragraph 13 of rule XXVI of the Standing Rules of the Senate. This is not a question of which committee has the power over the purse. It is a question of whether Congress will maintain the power over the purse and deliberately exercise it.

Every year in appropriations bills, programs are terminated, reduced, or expanded based on performance and the availability of resources, pursuant to the budget resolution. Interest groups and program beneficiaries are required to give us their views annually. The competition for available dollars is intense. But so what? Whether it is health care, climate change, education, or other legislation, Congress should be very cautious about establishing new, long-term, mandatory funding streams because it fundamentally weakens our ability to control Federal spending at a time when we greatly need to exercise that control.

I hope my colleagues will keep this in mind as we proceed with the business before us.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, shortly we will have an opportunity to vote on moving forward and considering health care reform in this country. I thank the majority leader, Senator REID, for putting together the bill that came out of our two committees that accomplishes what I think are the three goals we need to accomplish in health care reform. I have been asked by the people of Maryland whether I would support a particular bill. I told them in order for me to vote for a bill, it has to do three things: First, it needs to bring down the cost of health care in America; second, it needs to provide an affordable quality insurance option to every American; and, third, it must be done in a fiscally responsible way.

The bill Senator REID is bringing forward accomplishes those three goals. First, it brings down the cost of health care in America by about $1 trillion. It does it by investing in prevention and healthy lifestyles; by cracking down on fraud, waste, and abuse; and by eliminating unnecessary administrative costs in our health care system. That is the way we should bring down health care costs in America. That will improve quality but bring down costs.

Second, this bill allows every American to have access to affordable health insurance and health care. The Congressional Budget Office estimates the bill will reduce the number of uninsured in America by 31 million. We will be able to get 98 percent of Americans who are in this country legally, citizens, covered by health insurance as a result of this legislation.

Third, this bill moves forward in a fiscally responsible way by not only staying within our budget but by actually reducing our budget deficit by $127 billion with no new tax burdens on middle-income families.

I am particularly pleased this bill will help middle-income families in America. Mr. President, I know you have received letters from your constituents. I have received letters from my constituents that tell us the status quo is unacceptable for middle-income families in America.

Let me give two examples of people who wrote to me. I got hundreds of letters from Marylanders telling me they cannot make it under the status quo. This is from Meg, from Rock Hall, MD. Rock Hall, MD, is on the eastern shore. She is a healthy, active 62-year-old woman. She plays tennis four times a week. She is not on prescription medicines and has never had a major medical issue.

She wanted to change her insurance coverage. She has insurance, but she wanted to go to a more affordable insurance plan for her family. She was denied coverage. Why? Because she had received counseling 3 years earlier due to a stressful family situation and because she had a slightly elevated cholesterol level. Her cholesterol has been brought under control taking over-the-counter medication, and she has not had counseling in over a year.

She writes to me, and how do I answer that? It says:

If I am considered high-risk, where does that leave Maryland residents who have serious health conditions, are on medications, or require on-going care?

Meg is absolutely right. The bill the leader is bringing forward will deal with middle-income families such as Meg's by telling health insurance companies they cannot participate in such discriminatory practices, by restricting preexisting conditions. In fact, Meg doesn't have preexisting conditions, but they are using that to deny her full coverage.

Earlier this week, Cynthia and Eric Cathcart came to us, came to this Capitol to tell us their stories. I must tell you, I was shocked to hear of their circumstance.

Here are two individuals who are self-employed, trying to make it. They have two children. They are trying to get along. Eric told us he is basically giving up on his business and is going to have to work for a larger company because he can't afford health insurance. Cynthia, who is a piano instructor, tells us the same story. Listen to this.

Here are a husband and wife, two children, and they cannot get an insurance policy to cover their whole family because of the preexisting condition restrictions. These are small business owners who are going to have to literally give up their businesses.

Today they have two separate insurance plans: one for the husband and child, one for the wife and child, because that is the only way they can get it. They have to pay two separate deductibles because they couldn't get an insurance plan to cover the family. The amount of money they are paying for health insurance is prohibitively expensive.

The status quo is not acceptable for the Cathcarts and should not be acceptable for any of us. Under the health care bill the leader is bringing forward, though, discriminatory practices by private insurance companies would be prohibited, and the Cathcarts would have the option of a lot of different plans they could choose from to cover their entire family without separate deductibles for different members of their family.

That is the type of health care reform we need that will help middle-income families in America. It will help middle-income families by bringing down the cost of health care. The cost of health care in America is growing at way too fast a rate. Ten years ago in Maryland it cost an average family about $6,000 for health insurance. Maybe their employer paid part; maybe they paid part. Today that is $12,000 a family. By 2016 it will be $24,000 a family if we do not take action. We need to help middle-income families. We need to move forward with health care reform.

The average family in Maryland today is paying $1,100 per family for the cost of those who do not have health insurance. Those who have health insurance are paying for those who do not have health insurance.

That is why the bill the leader is bringing forward, that will cover 98 percent of Americans, is going to help middle-income families by eliminating that hidden tax of $1,100 per family in Maryland and around the country.

Health care costs are growing three times faster than wages are growing in America. Inaction should not be an option.

For small businesses the situation is very dire. They are spending 20 percent more than a comparable company that does the same business that is larger. Just as stressful, they cannot predict what the annual premium increase is going to be. How can you run a business without knowing what your costs are going to be from 1 year to another? For the sake of small businesses we need to move forward with health care reform.

A lot of families in Maryland depend upon Medicare; a lot of middle-income families in Maryland depend upon Medicare. This bill will strengthen Medicare by dealing with the underlying costs of health care, by getting that under control. At the same time we protect Medicare for the future, we provide additional benefits for our seniors by starting to close the doughnut hole, getting prescription drug costs under control, and providing preventive care for our seniors. This legislation will help middle-income families by dealing with insurance reform and eliminating preexisting conditions. It will provide larger pools to offer more choice for middle-income families.

This legislation will help workers who work for small companies. It will help those people in our community who have preexisting conditions. It will help those people in our community who are changing jobs. It will help those in our community who depend upon Medicare. This is legislation that is critically important for middle-income families in America.

The status quo is unacceptable. We need to act, and we are going to have a chance to do that when we vote Saturday on proceeding with health care reform. I urge my colleagues to move forward on this vital legislation for America.

I yield the floor.

The PRESIDING OFFICER . The distinguished Senator from Utah is recognized.

Mr. BENNETT. Mr. President, I enjoyed listening to my colleague from Maryland. He says to us repeatedly the status quo is not acceptable. I agree with that. I would point out to him that the bill that has been presented to us by the majority leader guarantees the status will remain ''quo'' until 2014. This bill delays implementation until 2014. For 4 years the status will remain ''quo'' on key provisions.

Mr. CARDIN. Will my colleague yield on that point?

Mr. BENNETT. I am happy to yield.

Mr. CARDIN. Let me point out that much of the insurance reform takes effect immediately. The preexisting conditions are dealt with immediately. The larger pools for those who can't find health coverage, that is done and implemented immediately.

Mr. BENNETT. I understand, but the key provisions of the bill that cost significant money are postponed until 2014. Why? Because unless you make that postponement you cannot get the score down to the point where it is in the majority leader's bill.

The challenge is that the real cost of health care is substantially more than this bill demonstrates as it comes out of the Congressional Budget Office. Why? Because the Congressional Budget Office is required by law to give costs over a 10-year period. If this whole thing started at the time the bill was passed and ran for the whole 10 years, the cost would be so high that it could not be offset with the programs that have been put in the bill. So the easy way to save costs and bring it down below the level that is acceptable is to delay the implementation until 2014.

We saw that in the Finance Committee. The Baucus bill moved the date of implementation from January 1, 2013, to July 1, 2013, to save money. Now the Reid bill moves it from July 1, 2013, to January 1, 2014, an entire year of additional ''savings.''

These are not savings at all. These are simply a delay in the implementation and therefore a delay in the expenditures.

I want to move to the point the Senator from Mississippi was making with respect to the impact of this on the national debt and the national deficit. The last time we had a budget from President Bush, the last Bush budget said the total expenditures would be $3.1 trillion.

President Obama's budget called for expenditures of $3.6 trillion or ½ trillion more.

OK, ½ trillion more, you would assume, therefore, that the deficit that would occur would be roughly ½ trillion more than the Bush deficit. But the last deficit of the Bush administration, before the financial crisis hit us, was $116 billion. That is .1 trillion of the $3.1 trillion. And the first deficit of the Obama administration is $1.4 trillion.

You say: Wait a minute. Those numbers do not add up. The reason they do not add up is, we can control how much we spend, but we cannot control how much we take in. How much we take in is a function of the economy.

Let's go back to the budget that was submitted and passed by the Obama administration and passed on the floor of the Senate by the Democratic majority. It projected $2.2 trillion in revenue, and it projected $2.2 trillion in entitlement spending, mandatory spending. That meant that everything else in government had to be borrowed. Money for the Defense Department had to be borrowed, the State Department, all of our embassies overseas, all of that money had to be borrowed. The money for transportation, for the Federal Aviation Administration had to be borrowed. The money for national parks had to be borrowed. The money for education had to be borrowed.

It wasn't that the expenditures went up an extra $1½ trillion to get a $1.4 trillion deficit. It was that the revenues went down. Yes, the expenditures did go up. The expenditures under the Obama budget went up roughly $½ trillion from the expenditures under the Bush budget. But the big problem was, the revenues went down at the same time.

The cautionary tale that comes out of this is, again, we can control how much we spend, but we cannot control how much we get in. That is a function of the economy. Money does not come from the budget; money comes from the economy. When the economy is weak, as it is now, we are going to have deficits, no matter how big an effort we make to try to avoid them, because the money simply doesn't come in.

The reason I make that point is because, back again to the numbers that we realized when we were debating the budget, the money coming in was $2.2 trillion and the money already committed in entitlement benefits that the Congress did not deal with in the appropriations process was $2.2 trillion. What we will do, if we pass the bill the majority leader has introduced or will introduce, is to increase the amount of mandatory spending, increase the commitment of the Federal Government to make expenditures in the health care area that will be beyond the reach of the Appropriations Committee, that will be going out whether or not we have the money coming in to pay for them.

I know the score out of CBO says this will save money for the Federal Government, but let's get into the details of what the CBO had to say to see how much it would save and see why it would save.

The CBO says, about the longer term calculations with respect to this bill:

> These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.

I think that is one of the understatements of the year. Major legislation does not often go unchanged for two decades. Congress will add goodies. Congress will delay some of the tax provisions. We see that every year with respect to the legislation known around here as the doc fix. It is in the law right now that every year we cut reimbursements to doctors under Medicare, and every year the Congress comes in and says: We won't do it this year. The doc fix comes in and says: We will change this earlier situation. That means any score that depends on our not passing a doc fix is going to be wrong. CBO says that. Again:

> These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades,

which is often not the case for major legislation.

We keep hearing how the costs are going to come down. What does CBO have to say about that? This is the quote that has to do with what I was talking about with respect to expanding the Federal commitment for entitlement spending in health care. Quoting again from CBO:

Under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

The Federal budgetary commitment to health care will increase. So how do we get a score that says we will save money? You get the score because you have projected revenues that will increase. You have tax provisions in there that say we will get the money from this tax, we will get the money from that tax. Then it will be a saving to the Federal Government. It is not a saving to the Federal Government; it is a raising of Federal revenues above the commitment to spend. But as I pointed out in the beginning, the raising of Federal revenues is not an automatic thing upon which we can depend. It is dependent upon the economy. What happens if we make the commitment to the spending and then the economy is not good and the revenues do not come in at the level CBO is projecting? These are all assumptions CBO is making, feeding into the computers. The computer cannot and does not project any kind of economic downturn, any kind of recession, any kind of problem. It just says: If, if, and if, you will get this number. And then they plug that number in, and that number says it will be big enough to pay for all of this. But make no mistake, what CBO says on the side where we can control it, the spending side, it says it would increase the Federal budgetary commitment to health care.

So once again we have entitlement spending. We have the demand for money going out going up on the hope that the revenues coming in will somehow be greater than the amount going up, and therefore we can project that this will save the government money.

How accurate has CBO been in the past with respect to the spending side? Well, we can go back to Lyndon Johnson and Joe Califano, who created Medicare, and take their original projections as to how much Medicare would cost. I have given that speech on the floor before. The answer is, Medicare costs 20 times more than was projected at the time it was put in place. We could do the same thing with Medicaid. It is not quite that big, not quite 20 times. SCHIP, whatever it is. With the exception of Medicare Part D, which was a Republican initiative, every single time the Federal Government has put in a Federal program for medical activity and medical expenditures, the actual expenditures have exceeded projections, sometimes 20 times exceeding it, going back to Medicare. That is the spending side.

We cannot produce that kind of money on the revenue side because we cannot really control the amount of revenue that comes in. The amount of revenue that comes in is a function of the economy.

Once again, where are we this year? Mr. President, $2.2 trillion in revenue, substantially below the amount of revenue that came in in the Bush administration. It is not Bush's fault that there was more or less. It was the economy that made a downturn. And if we think in this body we can repeal the business cycle and see there will be no more downturns in the future, we are really kidding ourselves. There will be downturns, and there we will be, with the commitment in place, the increase in the Federal budgetary commitment to health care, without the revenue to pay for it.

This is CBO again:

The long-term budgetary impact could be quite different if key provisions of the bill were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

In other words: We will make no attempt to guess what is going to happen in the future, but we can tell you that any kind of tinkering with this in the future is going to make all of our predictions wrong. That is the logical thing for them to say, it is the prudent thing for them to say, and it is the accurate thing for them to say.

There are many things about this bill that I don't like. I am convinced it will increase premiums for those who currently have health insurance. There is no way it can produce the kinds of results my friend from Maryland talked about of covering 30 million more people and cutting costs for everybody in Middle America without costing a lot more money someplace else. One of those places is going to be either in your tax responsibilities or in increased premiums or in the States.

We all know how the Governors feel about this proposal. The Governors have said this proposal will bankrupt us by the rolling of Medicaid costs onto the States—not Republican Governors, it is Democratic Governors who have come forward and said: We can't handle this. So there are lots of things about this bill I don't like.

But I believe the score that has been put together is not an honest one. I am not accusing CBO of doing anything wrong. I am accusing those who wrote the bill of putting in provisions so that we will delay this implementation there, we will call for this tax here and the score that goes there and so on. And it ends up that when we feed all of that information into the computer and then say: O mighty computer, none of this will change, what is the number, the computer gives you a number, but it is a number based on assumptions that are based on smoke and mirrors.

There is an old saying: Where there is smoke, there is fire. This bill has a lot of smoke in it, and, in my opinion, it is the American people who are going to get burned.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Mr. SPECTER. Mr. President, I have sought recognition to comment briefly on the Patient Protection and Affordable Care Act, which was disclosed late yesterday by our distinguished majority leader, Senator REID, to whom we all owe a debt of gratitude for the extraordinary work in putting together this very complex legislative proposal. Also, compliments are due to Senator BAUCUS, who chairs the Finance Committee, and Senator DODD, who carried on the work of Senator Kennedy on the Health, Education, Labor, and Pensions bill. The bill provides for gross spending of $979 billion over a 10-year period, under the $1 trillion dollar mark. The coverage allocation is $848 billion. There are gross savings of $1,109 billion, and the deficit impact is to have a reduction of some $130 billion over the 10-year period. In the second 10-year period, the projection for savings is substantially greater. There will be millions of Americans covered who do not now have health coverage, so over 94 percent of all legal residents of all ages will be covered.

We are now digesting this very complex piece of legislation. The majority leader has scheduled a cloture vote for Saturday at 8 p.m. It is my hope and, candidly, my expectation that we will have the 60 votes to proceed for the consideration of this bill.

It is my view that inaction is not an option; that there are too many people not covered by health insurance or who are underinsured. The cost of health coverage is escalating at such a tremendous rate. It is having a great impact especially on small businesses. A recent prominent publication noted that rates for small business were being dramatically increased. Senator HARKIN scheduled a hearing in the Health, Education, Labor, and Pensions Committee. One of my constituents from Lancaster came in to testify that his premiums were rising by 128 percent. So I believe that inaction is not an option.

We have had many declarations of positions, and in the Senate, where you need 60 votes to move ahead, every one of those votes is indispensable. Only one Republican, Senator SNOWE in the Finance Committee, supported the Finance Committee bill, so there was no

margin for error. It would be my hope that my colleagues will not draw any lines in the sand, realizing that no legislative proposal is going to meet the expectations and the desires of every individual Senator. There are 100 of us. There are 435 Members of the House of Representatives. If there is an art to politics, it is an art of listening, of being flexible, and accommodation or compromise.

So we are undertaking a major historic event. Efforts have been made since the days of Theodore Roosevelt to have this kind of health coverage legislation. It is too important for us to fail.

(The remarks of Senator SPECTER pertaining to the introduction of S. 2805 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

FORECLOSURES

Mr. SPECTER. Mr. President, while I have the floor, I wish to briefly address one other subject. I know my colleague is on the floor waiting for an opportunity to speak. This relates to a plan which is being carried on in the city of Philadelphia to stop foreclosures. We have seen a tremendous problem across America with the housing bubble, with so many people being in houses they could not afford and so many foreclosures. The Philadelphia program received front-page attention in the New York Times just yesterday as a model program. I call the Philadelphia program to the attention of my colleagues and to anyone who may be watching C–SPAN2, a program which is a model and which ought to be followed in other jurisdictions.

In March of 2008, the Philadelphia City Council passed a resolution called the Residential Mortgage Foreclosure Diversion Pilot Program. Following the council resolution, Philadelphia's civil court adopted rules that no owner-occupied house could be foreclosed on or sold at sheriff's sale before a mandatory conciliation conference between the borrower and lender aimed at finding a workable compromise. This Philadelphia program has emerged as a model, enabling hundreds of troubled home buyers to retain their homes.

In October of last year, a little more than a year ago, Senator CASEY and I held field hearings in Philadelphia and Pittsburgh to explore ways to keep borrowers in their homes using the successful Philadelphia program model.

I ask unanimous consent that at the conclusion of these remarks, a copy of the New York Times article be printed in full in the RECORD which details the Philadelphia program and is a suggestion for other cities as to how to follow that.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Nov. 18, 2009]

PHILADELPHIA GIVES HOMEOWNERS A WAY TO STAY PUT

(By Peter S. Goodman)

PHILADELPHIA.—Christopher Hall stepped tentatively through the entranceway of City Hall Courtroom 676 and took his place among dozens of others confronting foreclosure purgatory. His hopes all but extinguished, he fully expected the morning to end with a final indignity: He would sign over the deed to his house—his grandfather's two-story row house; the only house in which he had ever lived; the house where he had raised three children.

''This is devastating,'' he said last month as he sat in the gallery awaiting his hearing. ''This is my childhood home. I grew up there. My mother passed away there. My grandfather passed away there. All of my memories are there.''

A union roofer, Mr. Hall, 42, had not worked since August 2008, when the contractor that employed him as a foreman went broke and laid off more than 40 people. He had not made a mortgage payment in more than a year, and his lender, Bank of America, was threatening to auction off his house through the sheriffs office.

In most American cities, that probably would have been the end of the story: another home turned into distressed bank inventory by the national foreclosure crisis. But in Philadelphia, under a program begun last year to try to keep people in their homes, Mr. Hall entered the courtroom with a reasonable chance of hanging on.

Under the rules adopted by Philadelphia's primary civil court, no owner-occupied house may be foreclosed on and sold by the sheriffs office before a ''conciliation conference,'' a face-to-face meeting between the homeowner and the lender aimed at striking a workable compromise. Every homeowner facing a default filing is furnished with counseling, and sometimes legal representation.

So, as Mr. Hall stepped into the ornate courtroom just after 9 o'clock, he was swiftly provided with a volunteer lawyer, Kristine A. Phillips. She huddled briefly with a lawyer for Bank of America and returned with a useful promise. The bank would leave him alone for six more weeks while his housing counselor pursued further negotiations in an attempt to lower his payments permanently.

''You've got more time,'' Ms. Phillips told him. ''We'll get this all worked out,'' she said.

''Thank you so much,'' Mr. Hall said softly, his body shaking with pent-up anxiety now tinged with relief. ''It's a lot of weight off of my shoulders.''

In a nation confronting a still-gathering crisis of foreclosure, Philadelphia's program has emerged as a model that has enabled hundreds of troubled borrowers to retain their homes. Other cities, from Pittsburgh to Chicago to Louisville, have examined the program and adopted similar efforts.

''It brings the mortgage holder and the lender to the table,'' said City Councilor John M. Tobin Jr. of Boston, who is planning to introduce legislation to enact a program in his city modeled on Philadelphia's. ''When people are face to face, it can be pretty disarming.''

When homeowners in Philadelphia receive legal default notices from their mortgage companies, the court system schedules a conciliation hearing. Canvassers working for local nonprofit agencies visit foreclosed homeowners, distributing fliers that inform them of their rights to a conference, and urging them to call a hot line that can direct them to free housing counselors.

''You can feel a certain sense of relief from their just being able to speak to someone about the program,'' said Anna Hargrove, who works as a canvasser in West Philadelphia.

Every Thursday morning, the courtroom on the sixth floor of the regal City Hall here is given over to the conciliation conferences. It fills up with volunteer lawyers in jogging shoes, who are representing homeowners; gray-suited corporate lawyers working for mortgage companies; and all variety of delinquent borrowers—elderly citizens leaning on canes, construction workers in coveralls, parents with bored children in tow. The lawyers exchange preliminary settlement terms, while the homeowners fill out papers and wait.

In some cases, deals are struck that lower monthly payments for borrowers and allow them to retain their homes. When a homeowner cannot afford the home even at modified terms, the program helps to create a graceful exit, in which the borrower accepts cash for vacating the property or signs over the deed in lieu of further payment.

Those outcomes are similar to the ones produced by the Obama administration's $75 billion program aimed at stemming foreclosures, which gives cash subsidies to mortgage companies as an inducement to accept lower payments. But in Philadelphia there is one crucial difference: the mortgage companies have no choice but to participate. They have to attend the conferences and negotiate in good faith or they cannot proceed with a sheriffs sale.

Since the administration's program was begun in March, it has been plagued by complaints of bureaucratic confusion and the indifference of mortgage companies. Many homeowners who have applied for loan modifications complain that their documents have been lost repeatedly or that they have been rejected without explanation.

RIGHT TO MEDIATION

The Philadelphia program forces an outcome by bringing together all the principals in one room. If the mortgage company proves intractable, the homeowner has the right to request mediation in front of a volunteer lawyer serving as a provisional judge, who relays recommendations to the program's supervising judge. If the judge finds that the mortgage company is not acting in good faith, she can hold the house in limbo by denying permission for a sheriffs sale.

While data is scant, a legal aid group, Philadelphia Volunteers for the Indigent Program, has complete information on 61 of the 309 cases it has resolved since October 2008 through the anti-foreclosure program.

Only five resulted in sheriff's sales, while 35 ended with loan modifications that lowered payments, the group says. The remaining 21 cases were divided among bankruptcies, loan forbearance and repayment arrangements, graceful exits and straightforward sales.

Some suggest the city's program is plagued by the same basic defect as the Obama rescue plan: Nearly all the loans that have been modified have been altered on a trial basis, requiring homeowners to reapply for an extension of the terms after only a few months—a process that appears rife with obstacles, according to participants.

''There's no teeth to the conciliation program,'' said Matthew B. Weisberg, a Philadelphia lawyer who represents homeowners in cases involving alleged mortgage fraud. ''It's a largely ineffective stopgap prolonging what appears to be the inevitable, which is the loss of homes.''

Still, Mr. Weisberg grudgingly praised the plan.

''It's arbitrary and unpredictable,'' he said, ''but it's better than what anybody else is doing.''

SHERIFF DELAYS AUCTION

Philadelphia's Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March 2008, calling on Sheriff John D. Green to scrap the sheriff's sale scheduled for April. Low-income neighborhoods were already experiencing a surge of foreclosures involving subprime loans given to people with tainted credit. With unemployment growing, lost paychecks were now pushing people into delinquency, reaching into middle-class and even wealthy neighborhoods. In early 2008, nearly 200 homes a month were being auctioned by the sheriff's office, about one-third more than in 2006.

In West Philadelphia, Councilman Curtis Jones Jr., one of the sponsors of the resolution, watched his childhood neighborhood consumed by foreclosure, as the homes of working families—their porches once lined with flower pots—were boarded up with plywood.

''It becomes a blight on your entire community,'' Mr. Jones said. ''It creates an environment that fosters everything bad, from prostitution to drug dealing to wildlife, like raccoons taking over whole houses. One house becomes 10, and 10 becomes the whole block.''

In response to the resolution, Sheriff Green canceled the April sale. Meanwhile, Judge Annette M. Rizzo, who oversaw a local task force on stemming foreclosures, joined with the president judge of Philadelphia's Court of Common Pleas to develop the program.

For Judge Rizzo, a high-energy woman who has long taken an interest in housing policy, the moratorium presented both a crisis and an opportunity. The sheriff was effectively refusing to fulfill his mandated responsibilities, leaving his office vulnerable to legal challenge. But if the mortgage companies could be persuaded to participate in an alternative way of addressing foreclosures, more people could stay in their homes.

''I realized we're either going to go down in flames or we're going to be a national model,'' Judge Rizzo said. ''We're going to look at these cases and see what we can work out.''

Mr. Hall knew none of this. What he knew was that his life seemed to be unraveling.

HOME TO FOUR GENERATIONS

Ever since he was a teenager, he had earned a middle-class living with his hands. He had been raised by his grandfather in his three-bedroom house on Akron Street, in a predominantly Irish Catholic working-class neighborhood in Northeast Philadelphia.

He had attended St. Martin's, the Catholic school around the corner, married his childhood sweetheart and still remained in his grandfather's house, sending his own children—two boys (now in their 20s) and a 12-year-old girl—to the same school.

Mr. Hall, a soft-spoken yet intense man with a silver-tinged goatee, had worked seven days a week for much of this decade, bringing home weekly pay of about $1,000—enough to build a deck in his backyard; enough to obtain a fixed-rate mortgage and buy the house for $44,000 when his grandfather succumbed to Alzheimer's disease in the mid–1990s; enough for a motorcycle and a boat.

But three years ago, Mr. Hall committed the sort of mistake that has upended millions of households. At the recommendation of a for-profit credit counselor, he took out a new mortgage—a variable-rate loan from Countrywide Financial, which is now owned by Bank of America. He paid off some credit card debt, and he borrowed an extra $15,000 to renovate his home, expanding his mortgage balance to $63,000.

The loan began with manageable payments of about $500 a month. But Mr. Hall's interest rate soon soared—something he says was never explained to him—lifting his payments to $950 a month.

''When I got the mortgage, I didn't really understand it,'' he said. ''They told me this would improve my credit and that was it. It was just, 'sign here,' and 'initial here.' ''

NO MORE CONSTRUCTION WORK

He might still have managed had construction not come to a halt. By 2007, Mr. Hall's employer was cutting work hours. In August 2008, it shut down, turning his $1,000 weekly paycheck into an $800 monthly unemployment check.

Every day, he set the alarm clock and headed to the union hall at 5 a.m., waiting and hoping for work. Every day, he went home, still jobless and discouraged, now confronting the displeasure of his wife, who worked as a nurse, and who he said never came to terms with their diminished spending power. After months of bickering, she left him last December, taking their daughter.

''She was saying, 'How are we going to have Christmas? How are we going to go on vacation?' '' he recalled. ''She just seen it getting worse instead of better, and she got depressed.''

In January, his truck was repossessed, leaving him to walk through the winter dawn to the union hall for his daily ritual of defeat.

He watched the For Sale signs proliferating on his block, as mostly elderly neighbors found themselves unable to make their mortgage payments. He saw their belongings piled up on their front lawns as they abandoned their homes to foreclosure.

In September, the envelope finally landed with his default notice. A canvasser knocked on his door, proffering a flier urging him to call the city hot line. When he called, a housing counselor helped him assemble the paperwork for a loan modification and prepare for his conciliation conference.

When he arrived inside courtroom 676 in October, Mr. Hall carried a sheaf of wrinkled papers in a white plastic grocery bag. He occupied a solid wooden chair as an announcer called off cases for hearing. ''Number 27, Wachovia Mortgage versus . . ..'' A girl no older than 6, with flower-shaped plastic barrettes in her hair, fidgeted as her mother applied for legal representation.

Mr. Hall was struggling to come to terms with what he assumed was the end.

''I put my whole life into this house,'' he said. ''After I do all this work, they want to take it from me. You've got to regroup and move, but where? If I can't pay my mortgage, how am I going to pay rent? And I have a whole house full of furniture.''

When he got the news that he had a few weeks' reprieve, relief quickly gave way to the worry that had dominated his thoughts for months.

''It's postponing the inevitable,'' he said.

''I'm a man,'' he kept saying, trying to make sense of how a lifetime of working on other people's homes had put him here, staring at the potential loss of his own home; still hoping for relief.

''I don't want no handouts,'' he said. ''I just want a reasonable loan that I can afford to pay so I can get on with my life.''

Mr. SPECTER. I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. THUNE. Mr. President, I ask unanimous consent that at the conclusion of my remarks, the Senator from Michigan, Senator STABENOW, be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. THUNE. Mr. President, we now have a draft of the Senate majority's health care reform bill, after spending several weeks behind closed doors producing that bill. Some of the details are starting to emerge.

I think it is critical that all Members in the Senate have an opportunity to look very closely at what is in the bill. It should come as no surprise that it is a 2,000-plus page bill. Much was made of the bill in the House of Representatives being a 2,200-page bill when it was all said and done. This one is 2,074 pages. It hasn't been amended yet, so that will probably expand it as this bill comes to the floor.

I think we at least now have something we can look at and review. There was a lot made last night by the majority when they rolled this bill out—how fiscally responsible this bill is and how much of an improvement it is over recent drafts of this legislation. I wish to point out a couple things that I think, perhaps, put into perspective what this bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen.

First is with respect to the costs. It is very clear the cost of this bill—which was stated last night as $849 billion—is dramatically understated relative to its true cost when fully implemented. There are several reasons. One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014.

However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would begin to take effect immediately, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2014.

That distorts the true picture of what this legislation would cost and distorts it substantially.

The other point I will make is that there are a couple other provisions in the bill that, by its absence in one case and its inclusion in the other, understate the cost of the bill. One is the absence of the sustainable growth rate formula, or the so-called physician fee fix, the reimbursement form, that is a $247 billion hole—$247 billion in additional spending that is not included in the bill. That, obviously, understates the overall cost.

There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget

Committee in the Senate. He called the CLASS Act ''a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of.'' That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the $72 billion it shows as revenue in the first 10 years turns into a deficit in the second 10 years. So when you back out the $72 billion that, it is assumed, would add to the revenues in the bill and you add to the cost of the bill the $247 billion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of $130 billion to a deficit of $189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remember, when the HELP Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was $2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the committee, the 10-year, fully-implemented cost of that bill was $1.8 trillion. So that is $1.8 trillion for the Finance Committee bill and $2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what the pricetag is on the bill that was merged together and has now been unveiled for all the world to see. It is $2.5 trillion in overall cost—10-year, fully-implemented cost. That is a $2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the bill to make it look like it comes in under $1 trillion, when, in fact, when you back out the two components I mentioned, it is over $1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation date and the other gimmicks in here, it is $2.5 trillion in additional costs to the taxpayers of this country. Of course, that $2.5 trillion has to be paid for somehow. The way it is paid for isn't any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals to home health agencies, to hospice—you name it—and medical device manufacturers get hit hard in this legislation. Everybody gets hit when it comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—$½ trillion in tax increases and $½ trillion in Medicare cuts to finance this $2.5 trillion expansion of the Federal Government to create a new entitlement program.

The other thing this bill does, which wasn't included in a previous version, it has an increase in the payroll tax on Medicare. The argument is, it only applies to people in the higher income categories. They tried to carve out people under $200,000 a year. Remember, the Medicare tax—and the payroll tax that every employee in this country pays, which is 1.45 percent on their income, matched by their employer, for a total of 2.9 percent—is increased. It gets increased to pay for not reforming or making Medicare more sustainable, a program we all know is destined to be bankrupt by 2017.

The increase in the Medicare tax will fund a whole new entitlement program unrelated to Medicare. The argument will be it is a health care program. But the fact is, the Medicare payroll tax was put into place to fund Medicare, a program people would pay into so that when they retire, they would have the security of health care coverage.

The payroll tax included in this bill, first off, will hit a lot of people. If you are a couple who both make a couple hundred—or $100,000 a year, you are already into the category where you are going to be hit by the tax. One of my main objections—and I am not for this tax increase—one of my main objections is the majority has chosen to use that tax increase not to make Medicare more sustainable but to create a whole new entitlement program with this bill.

The other thing I wish to point out, because it has come up in the last day or two, is there has been all this discussion about mammograms, this U.S. Preventive Services Task Force that came out with a recommendation that women under 40 should not go through mammogram screening; and, of course, a few years ago they made the opposite recommendation—back in 2002—when the U.S. Preventive Services Task Force made the recommendation that women 40 and older should undergo annual mammogram checks for breast cancer. That recommendation was completely reversed earlier this week. The 16-member task force ruled that patients under 50 or over 75, without special risk factors, no longer need annual screening. What is being said about that? They are backing away from that in a hurry. The HHS Secretary, Kathleen Sebelius, said: No, no, no, nothing will change. This is just a recommendation. It is not binding.

That may be true today. Here is the problem with government-run health care, the problem with the direction we are heading with this legislation: A greater level of government involvement and intervention and more requirements imposed on those who offer insurance products, particularly those who contract with the government. I think it is safe to assume that. There are many new creations in this legislation, and there is a new Medicare advisory board. They will have recommendations that are not just recommendations and advisory but, in fact, binding.

This is exactly the point many colleagues have been making about government-run health care. When you start down that path—and we have seen the model in Europe and Canada—where the government imposes cost control measures, that leads to rationing. Pretty soon, people are denied care, and care is delayed when people want to get a particular procedure. It has been concluded that this is not cost-effective, and some of these decisions that have traditionally been made between patients and doctors are made by the government.

I will read for you something that was in an editorial in the Wall Street Journal today. It gets at the very heart of what I am talking about. It says:

> More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers are required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.
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> In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thral, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to ''accounting exercises subject to interpretations and underlying assumptions,'' and based on costs and large group averages, not individuals.

He goes on to say:

> I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.

What is important about that observation is that he is pointing out what a lot of people will be very concerned about. If you are a woman in my home State of South Dakota, and let's say you are 42 years old, the recommendation made by this task force, which everybody is now dismissing and saying don't worry about it, it is not binding—under legislation such as this, where you create a board that actually does have statutory powers and is enabled to make many of these decisions based on what is cost-effective, you could have someone in a State such as mine, or any woman in any State in this country who is in their forties—because they said 50 should be the baseline now, the age at which you get mammograms or breast cancer screening done—that you could actually have women in this country who would be denied the opportunity to do that.

Of course, we all know and everybody can relate to people in this country

who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country.

That is one example. I use that as an example of how this new type of government-run program might work. But there are countless other examples of the very same thing.

As we head into this debate, again I remind my colleagues this type of undertaking—reforming health care—ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority's bill that was unveiled yesterday that it actually increases costs by $160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern they have about health care today, is its costs. Everything we have seen so far, including this most recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this one as well that the proposals and all the new provisions that will be included—again, $2.5 trillion, 10-year fully implemented costs paid for by Medicare cuts, $½ trillion in Medicare cuts, $½ trillion in tax increases, and obviously much more than that when you get into the fully implemented time period, all that—all that—to raise health care costs for people in this country. How can we label that reform?

I hope the American people, as they listen to this debate, will engage, will take a hard look at this 2,074-page bill. It is going to be a lot of legislative, arcane language. We are all going to do our best to make sense out of it. But it is a massive bill, just in terms of its volume. It also includes a massive expansion of the Federal Government in Washington, DC, at tremendous cost to the taxpayers, to Medicare beneficiaries and, in the end, doesn't do anything to drive down the cost of health care. It simply increases it and puts at risk, I would argue, many of the types of things I talked about with regard to breast cancer screening. When government is making decisions rather than patients and doctors, that is a world in which I don't think I want to enter, and certainly I think most Americans don't either.

Mr. President, I ask unanimous consent to have printed in the RECORD a Wall Street Journal editorial.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

A BREAST CANCER PREVIEW

A government panel's decision to toss out long-time guidelines for breast cancer screening is causing an uproar, and well it should. This episode is an all-too-instructive preview of the coming political decisions about cost-control and medical treatment that are at the heart of ObamaCare.

As recently as 2002, the U.S. Preventative Services Task Force affirmed its recommendation that women 40 and older undergo annual mammograms to check for breast cancer. Since regular mammography became standard practice in the early 1990s, mortality from breast cancer—the second leading cause of cancer death among American women—has dropped by about 30%, after remaining constant for the prior half-century. But this week the 16-member task force ruled that patients under 50 or over 75 without special risk factors no longer need screening.

So what changed? Nothing substantial in the clinical evidence. But the panel—which includes no oncologists and radiologists, who best know the medical literature—did decide to re-analyze the data with health-care spending as a core concern.

The task force concedes that the benefits of early detection are the same for all women. But according to its review, because there are fewer cases of breast cancer in younger women, it takes 1,904 screenings of women in their 40s to save one life and only 1,339 screenings to do the same among women in their 50s. It therefore concludes that the tests for the first group aren't valuable, while also noting that screening younger women results in more false positives that lead to unnecessary (but only in retrospect) follow-up tests or biopsies.

Of course, this calculation doesn't consider that at least 40% of the patient years of life saved by screening are among women under 50. That's a lot of women, even by the terms of the panel's own statistical abstractions. To put it another way, 665 additional mammograms are more expensive in the aggregate. But at the individual level they are immeasurably valuable, especially if you happen to be the woman whose life is saved.

The recommendation to cut off all screening in women over 75 is equally as myopic. The committee notes that the benefits of screening ''occur only several years after the actual screening test, whereas the percentage of women who survive long enough to benefit decreases with age.'' It adds that ''women of this age are at much greater risk for dying of other conditions that would not be affected by breast cancer screening.'' In other words, grandma is probably going to die anyway, so why waste the money to reduce the chances that she dies of a leading cause of death among elderly women?

The effects of this new breast cancer cost-consciousness are likely to be large. Medicare generally adopts the panel's recommendations when it makes coverage decisions for seniors, and the panel's judgments also play a large role in the private insurance markets. Yes, people could pay for mammography out of pocket. This is fine with us, but it is also emphatically not the world of first-dollar insurance coverage we live in, in which reimbursement decisions deeply influence the practice of medicine.

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers will be required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to ''accounting exercises subject to interpretations and underlying assumptions,'' and based on costs and large group averages, not individuals.

''I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.'' Dr. Thrall continued. He's not overstating the case, as the 12% of women who will develop breast cancer during their lifetimes may now better appreciate.

More spending on ''prevention'' has long been the cry of health reformers, and President Obama has been especially forceful. In his health speech to Congress in September, the President made a point of emphasizing ''routine checkups and preventative care, like mammograms and colonoscopies—because there's no reason we shouldn't be catching diseases like breast cancer and colon cancer before they get worse.''

It turns out that there is, in fact, a reason: Screening for breast cancer will cost the government too much money, even if it saves lives.

Mr. THUNE. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Ms. STABENOW. Mr. President, first, it is a good thing our health care reform doesn't do the kinds of things the Senator is talking about. I wouldn't support it either. I don't think the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill.

Let me first start by saying, as the Chair knows and has said, this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing newspapers, dueling newspapers on the floor. Nicholas Kristof did a column called ''The Wrong Side of History.'' I quote:

Critics storm that health care reform is ''a cruel hoax and delusion.'' Ads in 100 newspapers thunder that reform would mean ''the beginning of socialized medicine.''

The Wall Street Journal's editorial page predicts that the legislation will lead to ''deteriorating service.'' Business groups warn

that Washington bureaucrats will invade ''the privacy of the examination room,'' that we are on the road to rationed care and that patients will lose the ''freedom to choose their own doctor.''

All dire—but also wrong. Those forecasts date not from this year, but from the battle over Medicare in the early 1960s. The heirs of those who opposed Medicare, [who protected the insurance industry at that time] are conjuring the same bogymen [today].

Indeed, these same arguments we hear today against health reform were used even earlier, to attack President Franklin Roosevelt's call for Social Security.

I appreciate the concerns that have been raised, but this is a replay of a time in the sixties when there was a debate about whether seniors who couldn't find affordable insurance in America should have access to the health care they need and the insurance they need.

Thank goodness, Democrats at that time, the President, and the Democratic majorities in the House and the Senate, chose to stand up for seniors and to override the objections coming from the insurance companies and the insurance lobby and those making money off the system at that time.

Let me talk a little bit about what is at stake if we do nothing, because that is the first question. Why should we be doing something? Every single day—in fact, today—14,000 Americans got up with health insurance and by the time they go to bed tonight they will not have it because they have lost their job, because their business had to drop them because the costs went up too much, because they couldn't afford the explosion in premiums and copays.

Insurance rates will almost double by 2016 for families, up to $24,000 for a family of four. Businesses will see their costs double in the next 10 years. What is extremely concerning to me as a Senator of the great State of Michigan, where we have a lot of employer-based care, employers doing the right thing, working hard to try to continue to provide health care coverage, those increased costs, doubling the costs over the next 10 years will, in fact, cost us 3.5 million jobs. Health care reform is about saving jobs.

Family incomes will be reduced by $10,000. Every single day—right now—5,000 homes are foreclosed. About half the homes that are foreclosed every day are foreclosed because of a medical crisis, and most of those families had insurance but it did not cover the cost of their medical expense. And we know that 62 percent of the bankruptcies today are because of a health care crisis and health care bills.

The status quo is not acceptable. Doing nothing means costs will go up, the insurance industry will still stand between you and your doctor deciding the kind of care you should get and the doctors you should see. In many cases, most plans require a certain set of doctors, a certain set of parameters.

We will lose jobs if we do not act. We cannot afford to lose more jobs. We are committed to turning the economy around and putting people back to work.

What do we hear from our Republican colleagues? Wait, wait, wait. We heard that in committee. Wait, slow down, we are going to have a lot of efforts on the floor to slow things down, take hours and hours and hours, don't act. Wait, wait, wait. And while we wait, those who make a lot of money off the current system will continue to make a lot of money off the current system while people see their health care costs go up and too many families struggle every day to figure out how they are going to provide health care for their children and themselves.

Business as usual from insurance companies—that is what we hear from the other side. Let the insurance companies do it. Let the insurance companies make the decisions about when you will be covered, how you will be covered, what you are going to pay, whether your doctor is in network or out of network, and whether you will be able to see the specialist you want to see. Business as usual is OK. Higher costs for middle-class families and small businesses are OK.

We believe these things are not OK, that doing nothing is only going to explode the deficit, hurt businesses, hurt families. We are prepared to act.

What does this mean in saving lives and saving money? First, it strengthens and protects Medicare. I will talk a little bit more about that. Lowering costs for small businesses and families. We know right now the majority of those who are uninsured are working. They are working in a small business or they are working out of their home as a single entrepreneur. They are in their garage, frequently working on that next invention, or they are out as a realtor in the community.

For years we have been saying we should pool small businesses and entrepreneurs into a larger group so they could get a better rate, such as a big business. That is what this is about. Amazingly, this big government takeover we hear so much about is for less than 20 percent of the people in the country right now. Eighty percent of the people in the country get their insurance through their employer—about 60 percent. The rest through a public program of some kind—Medicare, VA for veterans, our military, Medicaid. We are talking about filling in the gaps for small businesses and individuals, providing them tax cuts so that health insurance is more affordable and pooling them together. That is what this is about.

We are going to stop the insurance company bad practices as I talked about before. We are going to focus on prevention and quality which saves us money over time. In fact, one of the biggest ways we will save money is by focusing on keeping people healthy, focusing on ways that we change a system so we are not paying for individual procedures, but paying for those things the doctor needs to do and wants to do in total to help you recover from an operation or have the treatment you need.

We are going to, importantly, reduce long-term costs, lower the deficit and reduce long-term spending. If we do nothing, costs will continue to go up and up and, unfortunately, because of family costs and business costs, we are likely to see care go down and down as they struggle to keep their heads above water.

Let me talk a little bit more about Medicare. This is so important, as we know. We are going to strengthen Medicare. We know, again, if we do nothing, it is predicted the Medicare trust fund will be insolvent in 2017. We have to act.

We are doing a number of things both to bring down costs by focusing on prevention, saying to seniors and people with disabilities that if you go in for that annual checkup, if you go in for preventive work and, yes, mammograms, or the dread colonoscopy, that you will be able to do that without costs. There will be no deductible and no copay.

We are going to lower the gap in the prescription drug program under Medicare. Right now we know there is a gap in coverage, and we are going to begin to close that and hopefully close that all the way over time.

We are going to prevent payment cuts to doctors. This is something about which I care very deeply. We are going to make sure the cut for next year of 21 percent does not take place for doctors. But we need to solve long term the formula problems that are putting at risk doctors' and patients' ability to see their doctor. We are committed to doing that, to working with physicians.

It is incredibly important that seniors right now who can, in fact, see the doctor they want—because under Medicare you can choose your own doctor—we want to make sure they can continue to do that.

We are going to reduce the deficit and protect Medicare for the future. This is very important. In fact, the payroll tax that was talked about by the Senator from South Dakota would go into the Medicare trust fund to help make sure we are doing that.

It is important we recognize that the AARP, which has endorsed the House bill and supports health care reform moving forward—they have not specifically at this point endorsed what Senator REID has brought before us today, but we are hopeful they will. We know they are supporting health care reform.

There is no question that AARP, a champion for seniors in this country, would not be supporting moving forward on health care reform, they wouldn't be supporting what the House did if, in fact, it did what our colleagues are saying on the other side of the aisle. They would not.

Unfortunately, we have had too many seniors who have been scared. I, frankly, think that is shameful, the

kind of misinformation that is being given out to seniors. I know my mom, at 83, was initially concerned about what she was hearing until I walked through what we are doing. By the way, I think you would have to wrestle my mother to the ground to take away her Medicare card.

The reality is, this is a great American success story, and we want to keep it that way.

The reality is also that the AARP Web site talks about the myth that health care reform will hurt Medicare. This is from them, from their Web site. I welcome anyone to check it out. The myth is that we would be hurting Medicare.

Fact: None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

None of them would cut Medicare benefits or increase your out-of-pocket costs.

Fact: Health care reform will lower prescription drug costs for people in the Medicare part D coverage gap or ''donut hole'' so they can better afford the drugs they need.

Fact: Rather than weaken Medicare, health care reform will strengthen the financial status of the Medicare program.

This is from AARP, not from the Senate, not from Democrats. This is from a group whose job, whose mission it is to analyze what we are doing here and call it as they see it on behalf of those who receive Medicare benefits.

It would be terrific if that stopped being a talking point.

Let me talk a little more about insurance reform.

Whether you have insurance now or whether you are in the less than 20 percent who are without insurance today, affordable insurance, who will be going into this new pool we have, the insurance exchange—we see broad changes that will benefit patients. We really are talking about patients, consumers, families benefiting from insurance reform.

We are going to end discrimination for preexisting conditions, whether your child has leukemia and you are worried about whether at some point they are going to be able to find insurance on their own as they get older, a child with disabilities, or someone with juvenile diabetes. Unfortunately, we have also seen this used to discriminate against women. We have seen insurance companies say pregnancy is a preexisting condition and use it not only against women but against men who are expectant fathers. We want to make it very clear that you cannot be discriminated against if you have either a temporary or a permanent health condition.

We are going to stop the practice of dropping you if you become seriously ill. I don't know how many times I have heard from people in Michigan who said: You know, I am doing fine, I am paying my insurance premiums, I have insurance coverage, I am doing fine. But they have never really had to use the insurance. They have been fortunate that no one in their family has gotten seriously ill. Then something happens—a cancer, serious car accident, some other diagnosis that is very serious—and then in too many cases we have seen the insurance company come back and look for a technicality in order to be able to drop them because they are now having to pay out money for health care. That is wrong. This process of rescissions needs to stop, and under health reform it will.

We also, again, are saying that as a matter of policy under insurance, preventive care should be free. You are paying a premium but no copays and deductibles. We want people to be able to go to the doctor to get the annual visit, to be able to get the screenings, to be able to get the other preventive services they need. We want to save lives. This saves lives and saves money. We want to make sure that happens.

Then we are eliminating the annual and lifetime caps, to be able to address the caps as well.

Also, I am very pleased about two other provisions I think are so important for families. One is to allow young people to be able to stay on their parents' insurance through age 26. I wish that had been in place a couple of years ago, actually. I know from experience that the first job a young person may get out of college may not have health insurance or they may come out of college and work one or two or three part-time jobs in order to put things together while looking for work. This is very important for young people, to give them the opportunity to stay on their parents' insurance until age 26. This is one of the provisions that will start immediately when the bill is enacted. I believe it is very important.

Another provision that will happen immediately that is particularly important for many people in my wonderful State is a provision that will help hold down costs for early retirees. I was proud to be the author, with Senator KERRY, of this provision. We have many people who are retiring at age 55. It may not be voluntary. To many people, it is not voluntary. If the company continues the insurance, it is expensive. A person is not eligible for Medicare yet, and when they are retired early, someone 55 to 64 is usually using more medical care, more health care services. So it tends to be higher cost.

We also now have situations such as the United Auto Workers have decided, in order to help their industry and their companies, that they would assume the costs of retiree insurance, and early retirees are finding it extremely difficult, as they put together the numbers, to pay for care. Going forward, when this bill passes we will be a partner with those businesses or entities providing early retiree insurance by providing coverage for catastrophic care. It is called reinsurance, but basically above a certain amount we will cover it as the Federal Government. Above a $15,000 amount of a particular health care cost or treatment, the company will know that the Federal Government will reinsure or cover that. That means the exposure for the company is capped, which means their costs will not go up. In fact, they should go down significantly for early retirees. It also means other entities as well should be able to more accurately plan based on this partnership between businesses, employer-based care, and the Federal Government. This is very significant.

Again, as I close, it is very important to stress what this is all about. There are many pieces to this. I invite anyone from Michigan, as we have done all year, to go to my Web site. We have the entire bill posted. We have done this at every step of the way. We will continue to do that as the debate moves forward, with amendments and so on. We welcome people to get engaged.

I have a Health Care People's Lobby that folks can sign up for e-mail, and we will keep you posted on what is happening, and you can share your thoughts, your feelings, and your stories about what health care reform would mean to you or what has happened to you as someone needing health care or not getting the health care help from your insurance company that you believe you should as someone who has been paying for health care.

We are in a position now, we are poised to do something that I believe should have been done years ago. Many have tried to do it.

I commend this President for making health care, health insurance reform, a top priority; for understanding that we are losing jobs overseas because we are not competitive internationally with other countries, that health insurance reform is about jobs. It is about saving jobs. It is about the cost of losing your insurance. It is about businesses seeing their costs go up. It is also about a moral imperative that says, if you loose your job, you should not loose your health insurance in the greatest country in the world.

This is about saving lives at every level. It is about saving money at every level—for families, individuals, small businesses, larger businesses, States, the Federal Government. This is about tackling what has become a huge cost to our economy and beginning to turn that. It will take time, but we have to begin to turn this ship so we can get these costs under control. Saving lives, saving money, protecting Medicare for the future, and stopping the insurance abuses that occur every day for too many families—that is what health insurance reform is all about.

I am so pleased and proud of our leader, Senator REID, and grateful for his leadership and amazing skill in bringing us to this point. I am so grateful for the leadership of Senator BAUCUS in Finance and Senator DODD and Senator HARKIN on the HELP Committee and everyone who has been involved in this effort.

It is worth the time, whatever it takes, to do this and get it right. Saving lives and saving money for American families and businesses, protecting Medicare, stopping insurance abuses—this is worth fighting for. I am very proud to be part of a group of people who have placed this as a top priority.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

INAUGURATION OF THE PRESIDENT OF AFGHANISTAN

Mr. KAUFMAN. Mr. President, today, I rise to recognize the inauguration of President Karzai, as he begins his second term as President of Afghanistan. This milestone presents a unique opportunity to begin a new chapter in Afghanistan's history, which I hope will be characterized by transparency, effective governance, accountability, and an even stronger partnership with America.

Our two governments share common interests in the success of Afghanistan and the stability of the region.

When I met with President Karzai during my September visit to Kabul, we discussed counterinsurgency strategy and the importance of stronger governance at all levels—national, provincial, and district. Counter-insurgency strategy has proven effective throughout the course of history, and good governance is essential for its success.

President Karzai knows that he must garner greater support among the Afghan people for his government because, ultimately, this is a battle for legitimacy between the Afghan government and the insurgents. We will continue to partner with the Afghans to defeat the Taliban, but counter-insurgency cannot succeed if the Afghan people believe their government is plagued by corruption.

I welcome President Karzai's recognition of corruption as a ''dangerous enemy of the state'' in his inaugural address earlier today.

His intention to create an anti-corruption unit is an important step to this end, but words are not enough. He must match this rhetoric with action, and immediately take steps to effectively address the problem.

No government official is above the law, and all should be held accountable for their actions. Numerous criminal cases involving government officials—such as recent allegations that the Afghan Minister of Mining accepted a $30 million bribe as part of an illicit deal with a Chinese mining firm—must be thoroughly investigated.

As President Karzai said today, government officials should register their earnings. Those who engage in corrupt behavior should face the full weight of the law and be brought to justice.

Corruption must be addressed for two primary reasons: one, to build the confidence of Afghans in their government; and two, to ensure that the government functions more effectively in providing essential services.

In order to fulfill these two goals, I urge President Karzai to appoint competent governors and cabinet members who respect the rule of law and human rights, and are unequivocally committed to the people of Afghanistan. The stakes are too high to revert to cronyism. Now is the time for President Karzai to appoint and support capable, effective, and law-abiding public servants.

The essential defense against the Taliban is an effective Afghan government. As such, I urge President Karzai to work with the United States and other international partners to produce specific and measurable guidelines for combating corruption, improving government transparency and accountability, providing essential services, strengthening rule of law tackling the drug trade, and improving the economic infrastructure.

Clear benchmarks must be set, and progress must be monitored to ensure compliance.

This plan cannot be limited to Kabul. It is critical that government officials in the provinces and districts are well qualified and empowered with the necessary authorities and budgets to improve the lives of all Afghans. We must work together to undermine the Taliban's foothold and role as the de facto provider of rule of law and basic services, especially in southern Afghanistan.

In addition to good governance and essential services a third element of success in counterinsurgency is the training and deployment of effective national security forces.

I welcome President Karzai's stated intention to assume complete Afghan control over security within 5 years. I also echo his calls for NATO partners to take more effective steps to accelerate the training of the Afghan National Army—ANA and Police—ANP.

Currently there are not enough Afghan and international forces on the ground to ''clear and hold'' against the Taliban. In fact, the number of trained Afghan security forces is less than one-third that of Iraq—a geographically smaller country with nearly the same-sized population.

The training of the ANA and ANP must be expedited to build a stronger force of needed counterinsurgents, with the near-term goal of transferring responsibility to the Afghans.

During my two trips to Afghanistan this year, it was clear that the Afghan people identified security as a key concern, and wanted a swift transition from international to Afghan forces. Americans also hope for a swift transition, so we can eventually end our military presence and bring our brave troops home to their families.

I fundamentally disagree with accusations by some in Afghanistan—including President Karzai—that the U.S. presence in Afghanistan is purely self-serving. We are committed to working with President Karzai to secure our shared objectives. It has been said that nations have no permanent allies, only permanent interests. As we stand on the cusp of history together, the United States and Afghanistan are allies with shared goals and coinciding interests.

As President Obama outlined in March, it is America's goal to disrupt terrorist networks in Afghanistan, to defeat al-Qaida, and to help to promote a more capable and effective Afghan government. The way to do this is to partner with the Afghan people to defend them against a resurgent Taliban. As Secretary Clinton said, these are mutually reinforcing missions.

There is an underlying urgency to this joint venture, and we cannot succeed without a true partner in the Afghan government.

In his inaugural address, President Karzai said the right things. Now is the time for implementation.

During my visits to Afghanistan, I was impressed by the resolve and vision of the brave people of Afghanistan. In the face of enormous challenges, the majority of Afghans have rejected the Taliban's oppression, and chosen to seek a better life for future generations.

Today represents an opportunity for President Karzai to fulfill the hopes and dreams of his people, and bring greater peace and prosperity to Afghanistan through good governance.

As he begins his second term, President Karzai must forge a path that will lead to a brighter future, free from corruption. We need leadership, resolve, and determination, if we are to be successful in Afghanistan.

AMERICAN EDUCATION WEEK

Mr. FEINGOLD. Mr. President, this week I join my colleagues and the Nation in observing the 88th annual American Education Week.

The United States of America has a rich history of providing a free public education to its children, and the education that millions of students receive every year opens countless doors of opportunity to these students. Teachers, administrators, and support staff in our Nation's communities plant the seeds of knowledge in our students, who are the future of the American economy, American innovation, and American society. And sometimes I do not feel like enough is said of these individuals who have dedicated their lives to the cause of public education and who have touched the lives of millions of children. So this week, let us reflect on the positive impact teachers and schools have on this country.

While enormous strides have been made in expanding access to public education since our Nation's founding, the United States still has a long way to go before we can say that every child in our Nation has access to a high-quality public education. There is

still a persistent achievement gap in many of our Nation's schools with respect to low-income and minority students. The nationwide high school graduation rate hovers around 70 percent and is even lower for students of color and low-income students. This is unacceptable and is a matter of fairness and equality that must be addressed. We can do better. We must do better. The future of our country rests on our efforts. Federal, State and local governments must work together to continue to support our educators and help ensure that every child has access to good teachers and high-quality schools.

That is why I am looking forward to working with educators as Congress undertakes the reauthorization of the Elementary and Secondary Education Act, also known as No Child Left Behind. We now have the opportunity to rethink the proper role for the Federal Government in education reform and how we can best support States and school districts as they continue to work to educate all our Nation's children and close the persistent achievement gap that still exists in too many of our Nation's schools. We need to work together to solve problems, strengthen our public school system, and make certain that all our students receive the education they deserve.

As Chief Justice Warren wrote when he delivered the opinion of the Supreme Court in the landmark Brown v. Board of Education decision:

> Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the state has undertaken to provide it, is a right which must be made available to all on equal terms.

More than 50 years later, these words still ring true, and as we celebrate American Education Week, let us honor the outstanding work that our Nation's educators do every day and recommit ourselves to working with these educators to address the continued inequities in American education so that all children, regardless of their background, can receive a high-quality public education.

COMBATING HUNGER

Mr. CARDIN. Mr. President, as we prepare to depart for the Thanksgiving break, I wish to thank those who work to combat hunger in this country and to commend the administration for its goal of eliminating child hunger by 2015. I encourage the administration to work with Congress to find solutions to achieve this goal and end hunger in America.

We must commit ourselves to solving this crisis. The U.S. Department of Agriculture has just released findings that 14.6 percent of Americans were ''food insecure,'' up from 11.1 percent in 2007. Food insecurity is measured by the number of persons who experience hunger at some point during the year because they could not afford enough food.

The Agriculture Department also found that one-third of these households had what the researchers called ''very low food security,'' which mans that they were forced to skip meals or cut portions. The other two-thirds of households got by only through reliance on food stamps, soup kitchens, and food pantries.

The nearly 4 percent increase in food insecurity between 2007 and 2008 is the largest since USDA began reporting hunger statistics in 1995. Even more disturbing, USDA reports that nearly 17 million children live in households where food was scarce at some point during the last year. This figure amounts to more than one out of every five children in the United States.

An astonishing 1.1 million children went to sleep hungry at some point in 2008—a 36-percent increase from 2007. In my State of Maryland, more than 135,000 children currently live in food insecure households. Sixty-three thousand of these children are under the age of 5.

No child should ever know what it means to be hungry. Childhood hunger hinders development in the long term, and children who are hungry have difficulty learning and are at much higher risk to be in poverty as adults. Hunger negatively affects children's behavior, school performance, and cognitive development.

As we celebrate this holiday season, it is important to reflect on how each of us can support our communities. In my home State, the employees and volunteers at the Maryland Food Bank provide 14 million pounds of food annually to those in need. Working with more than 1,000 partner organizations, including soup kitchens, senior centers, daycare centers and afterschool programs, the food bank works to fill unmet needs of Maryland families. In these difficult economic times, the services of the Maryland Food Bank are more important than ever.

During the past year, the staff at the food bank's facilities in Baltimore and Salisbury saw demand increase by 50 percent. Middle-class families who a year ago made donations to the food bank are now turning to the organization to put food on their own tables.

Americans with full-time jobs are the fastest growing cohort of those in need. As unemployment continues to rise, families are being forced to spend their savings and are too quickly moving from middle to low income. America's working poor are most at risk. They live from paycheck to paycheck and have no safety net if their company downsizes or their hours are cut. When money is short, Americans are forced to make excruciating choices.

It is estimated that one-third of Marylanders relying on food assistance must choose between buying food and paying utility bills. Fifty-three percent of those who receive food assistance have unpaid medical bills. The number of working poor families in Maryland is 70 percent higher than it was two decades ago.

In addition to the food bank, I also want to highlight the work of employees at the many social service agencies across our State. These dedicated workers devote their time and energy to helping their community and work side-by-side with the Maryland Food Bank and other organizations to provide meals and services to those in need.

For example, the Maryland Department of Education works closely with the Maryland Food Bank on several projects that provide students with nutritious meals. More than 303,000 Maryland children rely on free or reduced-price meals in schools. Through the Backpack Program, the food bank provides schools such as Baltimore Highlands Elementary with backpacks filled with food. Children receive the backpacks on Friday afternoons to ensure they are not hungry over the weekend.

Kids Cafe is an innovative partnership between the food bank, the Maryland Department of Education, and local afterschool programs that provides nutritious meals and teaches children how to make healthful food choices.

Our seniors are also at risk of food insecurity at much higher levels than the general population. I applaud efforts such as the SNAP Outreach Program in Maryland, which is a partnership between the USDA and local organizations to help register seniors for food assistance programs.

Despite these efforts, we need to do more. In my State alone, it would take 82 million pounds of food to support the more than 350,000 Marylanders in need every year.

We must recommit ourselves to serving our communities and work together to support those in need during these difficult times.

So as Senators and staff leave Washington for their home States and prepare to give thanks and enjoy the company of family and friends, I encourage us all to show our support for those who work daily to make mealtime possible for millions of Americans in need.

225TH BIRTHDAY OF FORMER PRESIDENT ZACHARY TAYLOR

Mr. WARNER. Mr. President, today I wish to recognize the 225th anniversary of the birth of MG Zachary Taylor, a Virginia native son and the 12th President of the United States of America.

Best remembered as a distinguished military hero, Zachary Taylor was known as a resourceful, steadfast, modest and compassionate commander who fought many successful battles, earning from his soldiers and countrymen the affectionate nickname ''Old Rough and Ready.''

Zachary Taylor's personal popularity increased as his national prominence spread. General Taylor defeated Henry Clay, Winfield Scott and Daniel Webster for the Whig Party Presidential nomination. Although he had not sought office, Zachary Taylor was elected the 12th President of the United States.

Slavery was the driving issue of the campaign and the primary challenge of Zachary Taylor's brief Presidency. In his inaugural address, Zachary Taylor promised that the preservation of the Union would be his first obligation. He was determined to find a solution to end slavery even though he was a southerner and a slave holder. Zachary Taylor urged settlers in New Mexico and California to bypass the territorial stage and draft constitutions for statehood. As Southern Democrats called for a secession convention, Zachary Taylor reacted with a bristling statement that he would hang anyone who tried to disrupt the Union by force or by conspiracy, setting the stage for the Compromise of 1850.

During his 15 months in office, Zachary Taylor also created the Department of the Interior and signed a treaty with Great Britain guaranteeing a neutral canal connecting North and South America.

After laying the cornerstone of the Washington Monument on July 4, 1850, Zachary Taylor fell ill and passed away. An unprecedented 100,000 people lined the funeral route to see the hero laid at rest.

On November 24, 2009, representatives of local, State and Federal Government will gather to honor one of Orange County's most famous native sons. First Day Issue Zachary Taylor Dollar coins will be given to county schoolchildren. Please join me in commemorating the life of Zachary Taylor and the courage and efforts during his term of office to bring a peaceful end to slavery in the United States.

ADDITIONAL STATEMENTS

TRIBUTE TO PETER S. LEVI

● Mr. BOND. Mr. President, today I wish to honor a fine Missourian, Peter S. Levi, for his distinguished career as well as his lifelong commitment to community and economic development.

Mr. Levi has worked tirelessly in developing and fostering economic development throughout the Kansas City area for over 30 years. He first became involved in the region as executive director of the Mid-America Regional Council. After 13 years as the executive director, he moved on to become president of the Greater Kansas City Chamber of Commerce.

Mr. Levi's lifelong dedication to the city of Kansas City and surrounding area is evident through his championing of Kansas City and its economic potential. His 19 years as one of the chamber's most effective presidents has seen the chamber grow to represent about 9,000 area businesses while expanding the chamber's annual budget to over $6 million.

Along with Mr. Levi's work with the Chamber of Commerce he has been an active member of several boards including the Kansas City Symphony, University of Missouri-Kansas City, Midwest Research Institute, University of Kansas Medical Center, and the Jewish Federation of Greater Kansas City.

Mr. Levi is a graduate of Northwestern University, B.A, and the University of Missouri-Kansas City, J.D., masters of law in urban legal affairs. He is married to Enid Levi and they have two sons Josh and Jeff.

Mr. Levi will retire from the Greater Kansas City Chamber of Commerce on December 31 of this year. From his honorable service to the community to his impeccable leadership within the Chamber of Commerce, Peter S. Levi has always worked to inspire those around him with his vigor, sense of duty, and pride in his community.

With his many Kansas City friends, I thank Pete for his service to the city of Kansas City, and I wish him all the best in his future endeavors.●

REMEMBERING LEWIS MILLETT

● Mrs. BOXER. Mr. President, I am honored to remember Lewis Millett—a recipient of the Congressional Medal of Honor, a retired Army colonel and a proud American who passed away on November 14, 2009.

Colonel Millett retired from the U.S. Army after a 31-year career that spanned three wars. He was awarded the Medal of Honor for leading a bayonet charge up a heavily defended hill during the Korean war. In his 31-year career in the Army, that included service in World War II, Korea and Vietnam, Colonel Millett received numerous awards, including the Distinguished Service Cross, the Silver Star, two Legions of Merit, three Bronze Stars, four Purple Hearts, and three Air Medals.

Born December 15, 1920, in Mechanic Falls, ME, Millett grew up in Massachusetts, where he joined the State National Guard. In 1940, with the war in Europe underway, he enlisted in the Army Air Corps. But after President Franklin D. Roosevelt said that no Americans would fight on foreign soil, he deserted the Army and joined the Canadian Army. When he arrived in Europe in 1942, the United States was in the war and he was allowed to transfer back to the U.S. Army.

As a member of the 27th Armored Field Artillery of the 1st Armored Division, Colonel Millett participated in the Allied invasion of North Africa, where he earned a Silver Star after driving a burning halftrack loaded with ammunition away from U.S. troops and jumping out before it exploded. After a year in combat, the Army reviewed his military record and convicted him of desertion. He was fined $52 and sentenced to 3 days hard labor. He was not required to do the hard time, and 2 weeks later he was made a second lieutenant.

After World War II, he returned to civilian status and joined the Maine National Guard. When the Army called for volunteers in 1949, he returned to Active Duty.

He later served in Korea as a company commander and in Vietnam as a military adviser with the intelligence program called Phoenix. Colonel Millett retired from the US Army in 1973.

He is survived by his sons, Lee and Tim, and daughter Elizabeth; a brother, Albert; three sisters, Ellen Larabee, Jean Pepin, and Marion Finnity; and four grandchildren. I extend my heartfelt condolences to them.

The military community, the State of California, and our Nation have lost a proud American and a great warrior.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Pate, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting nominations which were referred to the Committee on Foreign Relations.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 11:16 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1839. An act to amend the Small Business Act to improve SCORE, and for other purposes.

H.R. 1842. An act to amend the Small Business Act to improve the Small Business Administration's entrepreneurial development programs, and for other purposes.

H.R. 3014. An act to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in solo and small group practices, and for other purposes.

H.R. 3738. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes.

H.R. 3791. An act to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1839. An act to amend the Small Business Act to improve SCORE, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 1842. An act to amend the Small Business Act to improve the Small Business Administration's entrepreneurial development programs, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3014. An act to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in solo and small group practices, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3738. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3791. An act to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, November 19, 2009, she had presented to the President of the United States the following enrolled bills:

S. 748. An act to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the ''Cesar E. Chavez Post Office''.

S. 1211. An act to designate the facility of the United States Postal Service located at 60 School Street, Orchard Park, New York, as the ''Jack F. Kemp Post Office Building''.

S. 1314. An act to designate the facility of the United States Postal Service located at 630 Northeast Killingsworth Avenue in Portland, Oregon, as the ''Dr. Martin Luther King, Jr. Post Office''.

S. 1825. An act to extend the authority for relocation expenses test programs for Federal employees, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3724. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 170 and ERJ 190 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0687)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3725. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–500 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1039)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3726. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 2000 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0909)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3727. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; International Aero Engines AG (IAE) V2500–A1, V2527E–A5, V2530–A5, and V2528–D5 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0294)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3728. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Turbomeca S.A. ARRIUS 1A Turboshaft Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0348)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3729. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls–Royce plc RB211 Trent 800 Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–1369)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3730. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; 328 Support Services GmbH Dornier Model 328–100 and –300 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0616)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3731. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A340–200 and –300 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0907)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3732. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hamilton Sundstrand Power Systems T–62T–46C12 Auxiliary Power Units'' ((RIN2120–AA64)(Docket No. FAA–2009–0247)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3733. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Farm and Ranch Lands Protection Program'' (RIN0578–AA46) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3734. A communication from the Secretary of Defense, transmitting a report on the approved retirement of General Arthur J. Lichte, United States Air Force, and his advancement to the grade of general on the retired list; to the Committee on Armed Services.

EC–3735. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57923)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3736. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Final Flood Elevation Determinations'' ((44 CFR Part 65)(74 FR 57921)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3737. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57944)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3738. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57928)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3739. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of the Debt Guarantee Program to Provide for the Establishment of a Limited Six-Month Emergency Guarantee Facility'' (RIN 3064–AD37) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3740. A communication from the Secretary, Division of Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Regulation S–P (17 CFR Part 248, Subpart A)'' (RIN3235–AJ06) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3741. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Indiana'' (FRL No. 8980–4) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3742. A communication from the Director of the Regulatory Management Division,

Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Maryland, Ohio and West Virginia; Determinations of Attainment for the 1997 Fine Particulate Matter Standard'' (FRL No. 8982–6) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3743. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Virginia; Transportation Conformity Regulations'' (FRL No. 8983–1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3744. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval of the Clean Air Act, Section 112(I), Authority for Hazardous Air Pollutants: Perchloroethylene Air Emission Standards for Dry Cleaning Facilities: Commonwealth of Massachusetts Department of Environmental Protection'' (FRL No. 8974–5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3745. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Fuel Economy Regulations for Automobiles: Technical Amendments and Corrections'' (FRL No. 8982–1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3746. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants for Area Sources: Asphalt Processing and Asphalt Roofing Manufacturing'' (FRL No. 8983–6) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3747. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Paints and Allied Products Manufacturing'' (FRL No. 8983–5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3748. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Information Reporting Requirements Under Internal Revenue Code Section 6039'' (RIN1545–BH69) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Finance.

EC–3749. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Employee Stock Purchase Plans Under Internal Revenue Code Section 423'' (RIN1545–BH68) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Finance.

EC–3750. A communication from the Inspector General, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Review of Medicare Contractor Information Security Program Evaluations for Fiscal Year 2006''; to the Committee on Finance.

EC–3751. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Hong Kong relative to the design, manufacture, and delivery of the AsiaSat 5C Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3752. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad relative to the modification CH–47SD Chinook Helicopters to the CH–47F configuration for end-use by Singapore in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3753. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled ''Information Technology: Federal Agencies Need to Strengthen Investment Board Oversight of Poorly Planned and Performing Projects''; to the Committee on Foreign Relations.

EC–3754. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Listing of Color Additives Exempt From Certification; Astaxanthin Dimethyldisuccinate'' (Docket No. FDA–2007–C–0044) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3755. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, a report relative to a petition to add workers from Baker-Perkins Company in Saginaw, Michigan, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. DODD, from the Committee on Banking, Housing, and Urban Affairs, without amendment:

S. 2799. An original bill to expand the Iran Sanctions Act of 1996, to provide for the divestment of assets in Iran by State and local governments and other entities, to identify locations of concern with respect to transshipment, reexportation, or diversion of certain sensitive items to Iran, and for other purposes (Rept. No. 111–99).

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 1147. A bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment in the nature of a substitute:

S. 1261. A bill to repeal title II of the REAL ID Act of 2005 and amend title II of the Homeland Security Act of 2002 to better protect the security, confidentiality, and integrity of personally identifiable information collected by States when issuing driver's licenses and identification documents, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Erroll G. Southers, of California, to be an Assistant Secretary of Homeland Security.

*Daniel I. Gordon, of the District of Columbia, to be Administrator for Federal Procurement Policy.

By Mr. LEAHY for the Committee on the Judiciary.

Jane Branstetter Stranch, of Tennessee, to be United States Circuit Judge for the Sixth Circuit.

Christina Reiss, of Vermont, to be United States District Judge for the District of Vermont.

Abdul K. Kallon, of Alabama, to be United States District Judge for the Northern District of Alabama.

Victoria Angelica Espinel, of the District of Columbia, to be Intellectual Property Enforcement Coordinator, Executive Office of the President.

Benjamin B. Tucker, of New York, to be Deputy Director for State, Local, and Tribal Affairs, Office of National Drug Control Policy.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DODD:

S. 2799. An original bill to expand the Iran Sanctions Act of 1996, to provide for the divestment of assets in Iran by State and local governments and other entities, to identify locations of concern with respect to transshipment, reexportation, or diversion of certain sensitive items to Iran, and for other purposes; from the Committee on Banking, Housing, and Urban Affairs; placed on the calendar.

By Mrs. MURRAY (for herself and Mr. FRANKEN):

S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CRAPO (for himself and Mr. RISCH):

S. 2802. A bill to settle land claims within the Fort Hall Reservation; to the Committee on Indian Affairs.

By Mr. CASEY:

S. 2803. A bill to direct the Secretary of Health and Human Services to encourage research and carry out an educational campaign with respect to pulmonary hypertension, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SANDERS (for himself and Mr. GRASSLEY):

S. 2804. A bill to require employers to certify that they have not and will not lay off a large number of employees before they are allowed to employ foreign workers in the United States, and for other purposes; to the Committee on the Judiciary.

By Mr. SPECTER:

S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. ENSIGN (for himself and Mr. CARPER):

S. 2806. A bill to codify and enhance existing regulations designed to encourage individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and disease prevention; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEVIN (for himself, Mr. MCCAIN, Mr. CASEY, Mr. GRAHAM, Mr. LIEBERMAN, Mr. CORKER, and Mr. NELSON of Florida):

S. Res. 355. A resolution expressing the sense of the Senate that the Government of the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law; considered and agreed to.

By Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ):

S. Res. 356. A resolution calling upon the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay; to the Committee on Foreign Relations.

By Mr. INOUYE (for himself and Mr. REID):

S. Res. 357. A resolution urging the people of the United States to observe Global Family Day and One Day of Peace and Sharing; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 148

At the request of Mr. KOHL, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 148, a bill to restore the rule that agreements between manufacturers and retailers, distributors, or wholesalers to set the minimum price below which the manufacturer's product or service cannot be sold violates the Sherman Act.

S. 182

At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 182, a bill to amend the Fair Labor Standards Act of 1938 to provide more effective remedies to victims of discrimination in the payment of wages on the basis of sex, and for other purposes.

S. 332

At the request of Mrs. FEINSTEIN, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 455

At the request of Mr. ROBERTS, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five—Star Generals, George Marshall, Douglas MacArthur, Dwight Eisenhower, Henry ''Hap'' Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 850

At the request of Mr. KERRY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 850, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson—Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 883

At the request of Mr. KERRY, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 883, a bill to require the Secretary of the Treasury to mint coins in recognition and celebration of the establishment of the Medal of Honor in 1861, America's highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States, to honor the American military men and women who have been recipients of the Medal of Honor, and to promote awareness of what the Medal of Honor represents and how ordinary Americans, through courage, sacrifice, selfless service and patriotism, can challenge fate and change the course of history.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from Idaho (Mr. RISCH), the Senator from Mississippi (Mr. WICKER) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1076

At the request of Mr. MENENDEZ, the names of the Senator from Hawaii (Mr. AKAKA) and the Senator from Maryland (Mr. CARDIN) were added as cosponsors of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1147

At the request of Mr. KOHL, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Texas (Mr. CORNYN) and the Senator from Utah (Mr. HATCH) were added as cosponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1536

At the request of Mr. SCHUMER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1536, a bill to amend title 23, United States Code, to reduce the amount of Federal highway funding available to States that do not enact a law prohibiting an individual from writing, sending, or reading text messages while operating a motor vehicle.

S. 1559

At the request of Mr. KERRY, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1559, a bill to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and for other purposes.

S. 1705

At the request of Mr. BARRASSO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1705, a bill to suspend temporarily the duty on certain acrylic fiber tow containing a minimum of 92 percent acrylonitrile.

S. 1709

At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1709, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to establish a grant program to promote efforts to develop, implement, and sustain veterinary services, and for other purposes.

S. 1780

At the request of Mrs. LINCOLN, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1780, a bill to amend title 38, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1963

At the request of Mr. AKAKA, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

S. 2128

At the request of Mr. LEMIEUX, the names of the Senator from Idaho (Mr. RISCH) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. LUGAR, the names of the Senator from Arizona (Mr. KYL), the Senator from Tennessee (Mr. CORKER), the Senator from Massachusetts (Mr. KERRY) and the Senator from Delaware (Mr. KAUFMAN) were added as cosponsors of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol's termination on December 5, 2009.

S. 2730

At the request of Mr. BROWN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2743

At the request of Ms. SNOWE, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2743, a bill to amend title 10, United States Code, to provide for the award of a military service medal to members of the Armed Forces who served honorably during the Cold War, and for other purposes.

S. 2787

At the request of Mr. THUNE, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. RES. 316

At the request of Mr. MENENDEZ, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

S. RES. 337

At the request of Mr. ROCKEFELLER, the names of the Senator from Wyoming (Mr. ENZI), the Senator from North Dakota (Mr. DORGAN) and the Senator from Pennsylvania (Mr. CASEY) were added as cosponsors of S. Res. 337, a resolution designating December 6, 2009, as ''National Miners Day''.

AMENDMENT NO. 2785

At the request of Mr. COBURN, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from North Carolina (Mr. BURR) were added as cosponsors of amendment No. 2785 proposed to S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. MURRAY (for herself and Mr. FRANKEN):

S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. MURRAY. Mr. President, I rise today to talk about legislation that I introduced with Senator FRANKEN today that is essential to the academic success of millions of vulnerable children and youth.

The Educational Success for Children and Youth Without Homes Act responds to the growing crisis of homelessness in our Nation. The legislation will help homeless children and youth thrive in school, despite the constant moves, trauma, and loss associated with homelessness.

This legislation is needed now more than ever. The economic downturn and foreclosure crisis have had a significant impact on homelessness. Public schools reported a 17-percent increase in the number of homeless students in 2007. In Washington State, the number of homeless students has increased dramatically. For example, the number of homeless students enrolled in Whatcom County schools increased by 66 percent over the past 2 years; in Evergreen Public Schools, there has been a 56-percent increase over the past 2 years. This Fall, many schools face a veritable tidal wave of homelessness. Over one million children and youth are now homeless in our Nation.

The recession has contributed to homelessness among two groups of students: children who are homeless with their families, and youth who are homeless on their own. This reality was brought starkly to light in the recent New York Times series about runaway and homeless youth. The series found a 40-percent increase in the number of homeless youth living on their own last year, more than double the number in 2003. It concluded that ''Foreclosures, layoffs, rising food and fuel prices and inadequate supplies of low-cost housing have stretched families to the extreme, and those pressures have trickled down to teenagers and preteens.''

School offers homeless children and youth structure, normalcy, support, and hope—it is a place where they can obtain the skills that they will need to avoid poverty and homelessness as adults. Yet these students face great educational challenges. High mobility, precarious living conditions, and severe poverty combine to create major barriers to school enrollment and regular attendance. Many homeless children and youth lack basic supplies and a reasonable environment where they can do homework. As a result of their circumstances, homeless students often perform below their peers in math and reading and are more likely to be held back.

We must do more to assist these students so they do not continue to be left behind. The Educational Success for Children and Youth Without Homes Act of 2009 would do just that. The bill amends the McKinney-Vento Act's Education for Homeless Children and Youth program. It makes a strong law even stronger by reinforcing and expanding the law's key provisions: school stability, enrollment, and support for academic achievement.

This legislation will enhance the right of homeless children to stay in the same school, so that children who have lost their homes do not also lose their schools. It will assist schools in meeting the challenges of transporting homeless students by increasing the authorized funding level and allowing other Federal funds for educating low-income students to be used for homeless transportation. When staying in the same school is not possible, or not in a child's best interest, the legislation will help the student make a seamless transition to a new school.

This bill will help students like Kyle, a 4th-grade student in Spokane. Due to the instability of homelessness, Kyle moved around with his family most of his life. In fact, he moved eleven times. There were large gaps where he had not gone to school at all, because of his family's frequent moves. Yet although Kyle moved eleven times, the homeless education program in Spokane was able to keep him stable in one school. Because he had the opportunity to attend one school consistently, the school district was able to determine that his academic and behavioral struggles were caused by more than just homelessness: a special education evaluation revealed that he was nearly deaf in both ears. He now has hearing aids in both ears and told his teacher:

''I can hear now, and I am being good. I want to be a crossing guard.''

Yet many more children like Kyle are not receiving the assistance they need due to lack of funding. In fact, only 9 percent of school districts are able to receive funding through the McKinney-Vento program currently. This legislation would increase the authorized funding level, so that more school districts can participate in the homeless education program and reach more children and youth experiencing homelessness.

One of the most successful features of the McKinney-Vento program is the requirement for every school district to designate a liaison for homeless children and youth. Liaisons identify homeless students, ensure their enrollment and attendance, and connect them to community resources. Liaisons are the backbone of this program, the unsung heroes who have become a lifeline for children and youth in crisis. Yet most liaisons do not have the capacity to carry out their required duties; they wear many hats and struggle to meet the growing demands of this population. As a result, too many homeless children and youth are falling through the cracks and missing out on school. The Educational Success for Children and Youth Without Homes Act will strengthen the critical position of homeless liaison by ensuring that liaisons have the time, resources, and training to fulfill their mandated duties.

The Educational Success for Children and Youth Without Homes Act also recognizes the unique needs of certain groups of homeless children: preschool-aged homeless children, and unaccompanied homeless youth.

Young children who are homeless have higher rates of developmental delays and other problems that set them back as they start out life, yet they face numerous barriers to participating in early childhood programs. They miss out on services that can mitigate the harmful effect of homelessness on their development. This legislation will increase homeless children's participation in preschool programs by requiring public preschool programs to identify and prioritize homeless children for enrollment, and to develop the capacity to serve all identified homeless children.

Unaccompanied homeless youth struggle to go to school without the basic necessities of life or a parent to guide them. We must assist unaccompanied homeless youth to overcome the unique educational challenges related to being without a home and without a parent or guardian. This legislation will help ensure that unaccompanied homeless youth have the supports necessary to stay in school, graduate with their peers, and move on to a brighter future.

The history of litigation under the McKinney-Vento Act makes clear that we must do a better job helping educators learn about homelessness and support them in implementing the law. To this end, the legislation provides funding for technical assistance and training, and requires participation in professional development activities.

I am pleased to be joined by Senator FRANKEN in cosponsoring this legislation to assist homeless students, and I am honored to cosponsor Senator FRANKEN's legislation, the Fostering Success in Education Act, to assist students who are in foster care. These bills recognize the similarities, and the differences, between students who are homeless and those who are in foster care. It is our intention to work with our Senate colleagues to ensure that children and youth who are currently served through the McKinney-Vento Act under the category of ''awaiting foster care placement'' will be transitioned to the Fostering Success in Education program, so that their unique needs may be best met.

As we look forward to the reauthorization of the Elementary and Secondary Education Act, we must recognize that children who do not know where they will sleep at night, or where their next meal will come from, face far greater challenges than simply remembering to do their homework. We must acknowledge that children who bounce between schools with each change of residence have little hope of taking advantage of even the best school programs. The most qualified teacher, or the most exceptional math or reading program, will not benefit children who are not enrolled in school, not attending regularly, and not assisted to overcome the barriers caused by homelessness. The Educational Success for Children and Youth Without Homes Act builds upon the proven successes of the McKinney-Vento Act's Education of Homeless Children and Youth program, while addressing remaining challenges. It is critical legislation that will help ensure that the homeless children of today do not become the homeless adults of tomorrow.

Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster Care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRANKEN. Mr. President, a quality education can serve as a positive counterweight to the abuse, neglect, and instability that children in foster care have experienced. That is why Senator MURRAY and I are introducing the Fostering Success in Education Act. The act builds on previous Federal efforts to increase the school stability and success of foster children.

The very placement of children in foster care has deprived many children of their opportunity to obtain a decent education. The primary reason is that children in foster care frequently move between foster homes, and often change schools when they move. Research shows that students lose 4 to 6 months of educational progress each time they change schools. It therefore becomes nearly impossible for foster children—who change schools multiple times—to make significant educational progress.

Moreover, foster children often change schools in the middle of the school year. When this happens, it is hard for them to catch up with their classmates, since they didn't learn the material their classmates studied earlier in the year.

Because different schools offer different courses, it is also difficult for foster children to transfer their course credits from prior schools after they move. Many foster children therefore end up repeating courses and even grades.

But what is even more disturbing is that foster children are often segregated from other students, and inappropriately placed in separate schools at group foster homes and residential treatment facilities. At these separate schools, foster children typically receive a subpar education, making it difficult for them to transition smoothly to regular public schools later on.

As a result of all these challenges, many foster children fall behind their peers in school, lose hope, and ultimately drop out. Consider, for example, the school experience of Carrie, a 19 year-old young woman in Minnesota, who was placed in foster care in eighth grade. When Carrie moved to her first foster home, she had to transfer to a new school. Being uprooted from her family was difficult enough, but she also had to cope with the transition to her new school—just when she most needed the support of her friends and teachers at her old school. Moreover, because she changed schools in the middle of the school year, she found it difficult to keep up with her classmates in her new school.

There was no need to add further instability to Carrie's life by making her change schools. Her old school—the school that she had attended since kindergarten—was just 20 minutes away from her foster home. It would have been perfectly reasonable to transport Carrie back to that school.

Over her next 5 years in foster care, Carrie ended up 7 moving between 7 different foster care placements and schools. The schools where she spent most of her time in high school separated her from other children in her community, and offered her a low-quality education. For example, in ninth grade, Carrie attended a school at a residential treatment facility, where her education consisted of sitting in a classroom with children as young as ten, and filling out simple workbooks with little help from an instructor. Given the multiple educational disruptions Carrie experienced, it is not surprising that she believes she left high school with only a ninth grade education.

Unfortunately, Carrie's school experience is not unique. Many foster children in Minnesota, and across the

country, have experienced a similar pattern of moving between multiple schools, wasting time in segregated schools, and leaving school without much to show for all their years of education.

Last year, Congress decided that it was time to do something about this situation. Congress enacted the Fostering Connections to Success Act, a child welfare law that, among other things, requires child welfare agencies to collaborate with local education agencies to improve the school stability of foster children.

Child welfare agencies, however, can't go it alone. To fulfill the vision of the Fostering Connections Act, they need the full cooperation of State and local education agencies.

That is why Senator MURRAY and I have decided to place requirements on State and local education agencies that mirror those placed on child welfare agencies in the Fostering Connections Act. For example, our bill requires State and local education agencies to collaborate with child welfare agencies to provide foster children who move to new school districts with the right to attend their schools of origin—or, in other words, the right to attend their former schools or the schools they attended before they were placed in foster care.

If Carrie had this right when she was placed in foster care, she would have been able to remain in the school she had attended since kindergarten. When it's not in the best interest of particular foster children to remain in their schools of origin, our bill requires State and local education agencies to work with child welfare agencies to enroll foster children immediately in new schools. This is an important element of our bill because foster children often spend weeks out of school as a result of enrollment delays.

In addition, our bill provides funding to help school districts and child welfare agencies address the educational needs of foster children, such as funding to provide foster children with transportation back to schools in their former school districts.

Finally, our bill clarifies that foster children have a right to the same educational opportunities as other children in their community. This means, for example, that foster children cannot be placed in separate schools merely based on the misguided belief that foster children cannot fit in at a regular public school.

In addition to working with Senator MURRAY on the Fostering Success in Education Act, we have collaborated on a related bill—the Educational Success for Children and Youth Without Homes Act, which Senator MURRAY introduced earlier today. The Educational Success for Children and Youth Without Homes Act will improve the educational stability of homeless children, who, like foster children, face significant educational challenges because they often move between school districts. While there are many similarities between the protections provided to homeless and foster children in our bills, our bills also address the unique circumstances of each group.

I am grateful to Carrie, and the many other foster and homeless youth who have bravely spoken out about their difficult school experiences. Their efforts will help prevent other children entering foster care or experiencing homelessness in the future from suffering similar ordeals.

I believe it is time that we listen to these youth and take steps to ensure that we don't deprive homeless and foster children of their right to an equal education. Senator MURRAY and I therefore plan on working hard in the coming months to achieve the reforms we lay out in the bills we're introducing today, and I would urge my colleagues to support both of these important bills.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2801

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Fostering Success in Education Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is the following:

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) FINDINGS.—Congress makes the following findings:

(1) Educational success is vital to every young person's well being, successful transition to adulthood, and economic stability.

(2) At the end of fiscal year 2007, approximately 500,000 children were in foster care in the United States, with nearly 800,000 children having spent at least some time in foster care in the United States during the year.

(3) Numerous studies have demonstrated that children in foster care fall behind the general student population with respect to test scores, graduation rates, and successful transitions to postsecondary education.

(4) Only one-third of high school students in foster care graduate on time and only 3 percent of such students graduate from college.

(5) On average, children in foster care move to new foster care placements 2 times per year, and often change schools when they move.

(6) Studies indicate that with each school move, children, on average, fall 4 to 6 months behind their classmates. Because foster children often change schools multiple times, it is difficult for them to make significant educational progress.

(7) Children in foster care are frequently denied the ability to remain in the same school as a result of changes in their living situations.

(8) In addition, children in foster care who are required to change schools are frequently denied immediate enrollment in a new school, which results in detrimental disruptions to their education.

(9) Moreover, the enrolling school frequently does not have access to the child's complete and accurate education records, which often results in the child's placement in inappropriate classes and educational settings.

(10) When foster children change schools, they often have difficulties transferring credits from previous schools and meeting the new set of graduation requirements in their new school.

(11) In 2008, Congress enacted the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351), which requires, among other things, child welfare agencies to ensure that a child in foster care remains in the same school after moving to a new placement or, when remaining in the same school is not in the child's best interest, is enrolled in a new school immediately, and that the child's education records are transferred promptly. While the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires child welfare agencies to coordinate with local educational agencies, the local educational agencies must play a critical role in the process. Otherwise, the education provisions of the Act cannot be fully implemented.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) in order to successfully meet the needs of the 500,000 children in foster care in the United States, State educational agencies, local educational agencies, State child welfare agencies, and local child welfare agencies must work together at the Federal, State, and local level to—

(A) address the unique needs of this population; and

(B) ensure school stability, immediate enrollment, and access to appropriate services; and

(2) such efforts will significantly increase the secondary school graduation rates and improve educational outcomes for children in foster care.

SEC. 3. PURPOSE.

The purpose of this Act is to ensure that the educational needs of children in foster care are addressed in a seamless and complete manner by—

(1) requiring the State educational agency of a recipient State to work together with the State child welfare agency to ensure that the educational needs of each child in foster care in the State are being met;

(2) requiring local child welfare agencies and local educational agencies of a recipient State to work together to ensure that the educational needs of each child in foster care in the State are being met;

(3) ensuring that issues related to stability in education, school attendance, and the proper handling of information, including education records and health records, are coordinated between schools and child welfare agencies; and

(4) ensuring that a coordinated process is utilized to address the best interest and needs of the child with regard to school placements, school attendance, access to appropriate education services, and required supports, including the provision of transportation services to ensure school stability.

SEC. 4. DEFINITIONS.

In this Act:

(1) CHILD IN FOSTER CARE.—The term ''child in foster care'' means a child whose care and placement is the responsibility of the State or Tribal agency that administers a State plan under part B or E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.), without regard to whether foster care maintenance payments are made under section 472 of the Social Security Act (42 U.S.C. 672) on behalf of the child.

(2) COURT REPRESENTATIVE.—The term ''court representative'' means an individual appointed by a court to represent a child in a juvenile court dependency proceeding.

(3) EDUCATION DECISIONMAKER.—The term ''education decisionmaker'' means—

(A) a parent of a child in foster care; or

(B) a person identified by the dependency court to make education decisions for a child in foster care who is someone other than the child's parent.

(4) EDUCATION RECORDS.—The term ''education records'' means documents and other materials relating to a child's enrollment and education, including transcripts, reports, plans, evaluations, and assessments maintained by a local educational agency.

(5) ELEMENTARY SCHOOL.—The term ''elementary school'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(6) ENROLLMENT.—The term ''enrollment'' means attending classes in a public preschool program, an elementary school, or secondary school and participating fully in the activities of such school or program.

(7) LOCAL CHILD WELFARE AGENCY.—The term ''local child welfare agency'' means, with respect to a child in foster care, the public agency in the local political subdivision where the child resides, or the Indian tribe or tribal organization, that is responsible for the placement and care of the child.

(8) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(9) PARENT.—The term ''parent'' means a biological or adoptive parent or a legal guardian of a child, as determined under applicable State law.

(10) PLACEMENT.—The term ''placement'' means the current or proposed living situation for a child in foster care, which can include a group home or other congregate care setting.

(11) PUBLIC AGENCY.—The term ''public agency'' means any State or local government entity.

(12) PUBLIC PRESCHOOL PROGRAM.—The term ''public preschool program'' means a preschool program funded, administered, or overseen by a State educational agency, local educational agency, or other State agency.

(13) RECIPIENT STATE.—The term ''recipient State'' means a State that receives funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.).

(14) SCHOOL OF ORIGIN.—The term ''school of origin'' means, with respect to a child in foster care, any of the following:

(A) The school in which the child was enrolled prior to entry into foster care.

(B) The school in which the child is enrolled when a change in foster care placement occurs or is proposed.

(C) The school the child attended when last permanently housed, as such term is used in section 722(g)(3)(G) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432(g)(3)(G)).

(15) SCHOOL ATTENDANCE AREA.—The term ''school attendance area'' has the meaning given the term in section 1113(a)(2)(A) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)(2)(A)).

(16) SCHOOL SELECTION DECISION.—The term ''school selection decision'' means a school selection decision as described in section 101(b)(4).

(17) SECONDARY SCHOOL.—The term ''secondary school'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801 et seq.).

(18) SECRETARY.—The term ''Secretary'' means the Secretary of Education.

(19) SPECIAL EDUCATION AND RELATED SERVICES.—The terms ''special education'' and ''related services'' have the meaning given such terms in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401).

(20) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(21) STATE CHILD WELFARE AGENCY.—The term ''State child welfare agency'' means the State agency responsible for administering the programs authorized under subpart 1 of part B and part E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.).

(22) STATE EDUCATIONAL AGENCY.—The term ''State educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

SEC. 5. REGULATIONS.

Not later than 60 days after the date of enactment of this Act, the Secretary shall develop, issue, and publish in the Federal Register a notice of proposed rulemaking to implement the provisions of this title. The issuance, amendment, and repeal of any regulations promulgated under this title shall comply with section 553 of title 5, United States Code.

SEC. 6. EFFECTIVE DATE.

Except as otherwise provided, this Act and the amendments made by this Act shall take effect on the date of enactment of this Act, except that subtitle A, and the amendments made by such subtitle, shall apply with respect to recipient States that receive funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) on or after the date of enactment of this Act.

TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

SEC. 101. REQUIRED EDUCATIONAL RIGHTS, PROTECTIONS, AND SERVICES FOR CHILDREN IN FOSTER CARE.

(a) RIGHTS OF CHILDREN IN FOSTER CARE.—Each recipient State shall ensure that each child in foster care in the State has the following rights:

(1) SCHOOL ATTENDANCE.—

(A) SCHOOL OF ORIGIN.—A child in foster care shall have the right to enroll in, or continue to enroll in, any of the child's schools of origin when the child is placed in foster care and during all subsequent changes in placement (including when the child returns home, as required under subparagraph (B)), unless it is determined through the school selection decision process that it is in the child's best interest to be immediately enrolled in a different school.

(B) SCHOOL UPON PERMANENT PLACEMENT.—In the case of a child in foster care for whom the child welfare case is closed as a result of the child returning home or achieving another permanency outcome during a school year—

(i) the child shall be entitled to complete the school year in the school that the child is attending unless the entity making the school selection decision determines that a change in schools is in the child's best interest; and

(ii) necessary transportation to the current school shall be arranged and funded by the local educational agency in which the current school is located.

(2) TREATMENT AS RESIDENT.—A child in foster care who remains in a school of origin shall be treated by the local educational agency serving such school as if the child resides in the school district and is entitled to all school privileges.

(3) IMMEDIATE ENROLLMENT.—If it is determined through the school selection process that it is not in the best interest of a child in foster care to attend a school of origin, or if a school selection decision is not sought for the child, the child shall have the right to be immediately enrolled in a new school in the child's school attendance area, regardless of the status of records normally required for enrollment such as previous academic records, medical or immunization records, proof of residency, or other documentation or requirements.

(4) RECORDS.—

(A) IN GENERAL.—The education records of a child in foster care shall be—

(i) maintained so that the records are available, in a timely fashion, when a child enters a new school or school district;

(ii) immediately sent to the enrolling school as complete as possible, even if the student owes fees or fines or was not withdrawn from the previous school in conformance with local withdrawal procedures; and

(iii) maintained in a manner consistent with section 444 of the General Education Provisions Act (commonly referred to as the ''Family''(20 U.S.C. 1232g).

(B) RECORDS FOR ACADEMIC DECISIONS.—The education records needed for academic placement decisions and decisions regarding the transfer of school course credits for a child in foster care shall be released immediately to an enrolling school by facsimile or other available electronic means.

(5) EQUAL ACCESS.—Each child in foster care shall have equal access to the same education and opportunities as other students attending the school or school district, including—

(A) having the same opportunities, access, and services needed to meet the challenging State student academic achievement standards under section 1111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) that are provided to other students;

(B) receiving educational services and transportation services that are comparable to the services offered other children in the child's school;

(C) having—

(i) equal access to the full range of educational offerings, including—

(I) services under title I of such Act (20 U.S.C. 6311 et seq.);

(II) publicly funded early childhood programs and public preschool programs;

(III) Early Head Start or Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.);

(IV) public charter and magnet schools;

(V) Advanced Placement courses and dual enrollment higher education courses;

(VI) career and technical education programs;

(VII) summer school; and

(VIII) extracurricular activities; and

(ii) as appropriate, prioritization in the educational offerings described in clause (i) in accordance with Federal and State law;

(D) being integrated with other students in all schools or programs within a school that are operated, licensed, or funded by a public entity;

(E) attending the elementary school or secondary school that serves the child's school attendance area unless—

(i) the student has an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414) requiring placement in an alternative setting, in another public school in the same or another local educational agency, or in a private school;

(ii) it is in the child's best interest to enroll in a school of origin that is not the school that serves the child's school attendance area, based on the school selection decision for the child; or

(iii) the education decisionmaker consents to another appropriate school placement.

(6) TRANSPORTATION.—

(A) IN GENERAL.—A child in foster care shall be provided with free transportation to and from the child's school of origin or other school in which the child is enrolled, in accordance with this subsection, paragraphs (4)(H) and (5)(D) of subsection (b), and section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)).

(B) CHILDREN WITH DISABILITIES.—In the case of a child in foster care that receives services under part A or C of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq., 1431 et seq.), nothing in this Act or section 475(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)) shall relieve a local educational agency of the agency's responsibility to provide the child with transportation as part of such services.

(b) REQUIREMENTS OF EDUCATION SYSTEM FOR CHILDREN IN FOSTER CARE.—In order to provide each child in foster care with the rights described in subsection (a), each recipient State shall meet the following requirements:

(1) POLICY REVIEW AND REVISION.—

(A) IN GENERAL.—Not more than 120 days after the effective date of this Act, any State or local educational agency in the State that has a school attendance law or other law, regulation, practice, or policy that may prohibit enrollment in, or attendance at, a school of origin for a child in foster care or that may prohibit implementation of any other requirement of this title, shall undertake steps to revise such law, regulation, practice, or policy to ensure that children in foster care—

(i) are afforded the same free, appropriate public education as is provided to other children; and

(ii) receive the protections of this subtitle.

(B) NO DELAY.—Nothing in this subsection shall be construed to permit a State or local educational agency to delay implementation of this Act until such review and revision is completed.

(2) COORDINATOR.—

(A) IN GENERAL.—The State shall designate a coordinator within the State educational agency to be the lead staff member to implement this title.

(B) COLLABORATION.—The coordinator shall collaborate with representatives from the State child welfare agency, the State's program supported under subtitle B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.), when appropriate, and with all other State and local agencies necessary to implement the requirements of this title and the provisions of parts B and E of title IV of the Social Security Act (42 U.S.C. 621 et seq., 42 U.S.C. 670 et seq.) relating to the educational needs of children in foster care.

(C) SPECIAL RULE.—In the case of a State that receives a grant under section 111 in an amount that is more than the minimum allotment described in section 111(b)(1)(B), the coordinator under this paragraph for the State shall not be the same individual who is assigned the role of State Coordinator for purposes of the State's program supported under subtitle B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432 et seq.).

(D) RESPONSIBILITIES.—The responsibilities of a coordinator described in subparagraph (A) shall include, at minimum—

(i) ensuring that the requirements of this title and clauses (ii)(II), (iii), and (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) are carried out;

(ii) gathering and making public information on the problems children in foster care have in gaining access to public preschool programs and schools;

(iii) monitoring the progress of the State and local educational agencies in addressing any problems or difficulties in meeting the requirements of this title;

(iv) ensuring the success of the programs under this title;

(v) providing technical assistance to local educational agencies and local child welfare agencies on how to comply with this title;

(vi) collecting data related to the implementation of this title and the educational outcomes of children in foster care and reporting such information to the appropriate State officials and to the Secretary; and

(vii) ensuring effective implementation of a dispute resolution procedure, as described in paragraph (5), and a complaint management system, as described in paragraph (6).

(3) FOSTER CARE LIAISON.—

(A) IN GENERAL.—The State educational agency shall ensure that each local educational agency in the State designates a foster care liaison with sufficient capacity, resources, and time to fulfill the requirements of this title effectively.

(B) RESPONSIBILITIES.—The foster care liaison shall ensure, at minimum, that—

(i) each child in foster care served by the local educational agency is—

(I) identified for purposes of this title;

(II) enrolled in the appropriate public preschool program or elementary or secondary school, in accordance with any school selection decision made for the child; and

(III) has a full and equal opportunity to succeed in the child's school program and receive educational services for which the child is eligible, including—

(aa) special education and related services and protections under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.);

(bb) programs under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.);

(cc) English as a Second Language programs, including programs under title III of such Act (20 U.S.C. 6801 et seq.); and

(dd) early childhood and preschool programs;

(ii) the parents and education decisionmaker of the child in foster care, and the child welfare agency representative, are informed of the opportunities available to the child under this title;

(iii) school personnel are adequately prepared to implement this title; and

(iv) the local educational agency serving the child works collaboratively with individuals designated by the local child welfare agency to ensure—

(I) that child welfare agency personnel are informed of the rights of children in foster care and responsibilities of the State and local agencies under this title;

(II) that a child in foster care in a school served by the local educational agency has school stability and is promptly enrolled in a school in accordance with any school selection decision made for the child;

(III) that the child is provided with special education evaluations and services, as needed, and if the child is a child with a disability, as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401), the arrangement for, and provision of, the transportation, records transfers, and special education and related services as required under such Act, including—

(aa) the timely conduct of evaluations as required by section 614(a) of such Act (20 U.S.C. 1414(a));

(bb) the prompt transmittal of records under section 614(d)(2)(C)(ii) of such Act (20 U.S.C. 1414(d)(2)(C)(ii)); and

(cc) when appropriate, the appointment of a surrogate parent for a child required under section 615(b)(2) or 639(a)(5) of such Act (20 U.S.C. 1415(b)(2), 1439(a)(5)); and

(IV) the appointment by the appropriate court of an education decisionmaker for the child for purposes of this title, as needed.

(4) SCHOOL SELECTION DECISION.—

(A) IN GENERAL.—Upon a request made in accordance with subparagraph (C), the appropriate entity described in subparagraph (B) shall make an individualized school selection decision on an expedited basis for a child in foster care regarding whether it is in the child's best interest to attend a school of origin or to be immediately enrolled in the appropriate school where the child resides.

(B) ENTITIES MAKING SCHOOL SELECTION DECISIONS.—The school selection decision shall be made by the local educational agency that serves the school of origin in which enrollment is sought for a child in foster care, unless the State determines the school selection decision shall be made solely by—

(i) the dependency court;

(ii) the State child welfare agency; or

(iii) the local child welfare agency.

(C) INITIATING A SCHOOL SELECTION DECISION.—

(i) IN GENERAL.—The local child welfare agency responsible for a child in foster care shall, after consultation with the child and with the education decisionmaker and parent of the child, initiate the school selection decision process under this paragraph if the agency believes that a child should remain or enroll in a school of origin.

(ii) TIMING.—A school selection decision may be requested for a child in foster care each time the child's placement is changed or a placement change for the child is proposed.

(iii) NOTIFICATION OF FOSTER CARE LIAISON.—The local child welfare agency shall notify the foster care liaison described in paragraph (3) for the local educational agency serving the school in which the agency wants the child to remain or enroll to initiate the school selection decision process.

(iv) EXCEPTION.—If the local child welfare agency has not initiated the school selection process, the child's education decisionmaker may do so by contacting the appropriate foster care liaison described in clause (iii).

(D) DEPENDENCY COURT DECISION.—Notwithstanding any other provision of this subsection, if the court with dependency jurisdiction over a child in foster care initiates or

makes a school selection decision for such child, or appoints another person to initiate or make a school selection decision, the court's determination shall be binding on all parties, the State educational agency, and the appropriate local educational agency.

(E) SOURCES OF INFORMATION; FACTORS.—

(i) SOURCES OF INFORMATION.—The entity making the school selection decision for a child in foster care shall consider information and factors provided by—

(I) the State child welfare agency, local child welfare agency, State educational agency, local educational agency, or other public agency; and

(II) individuals who have knowledge about the child's education, including the child and the parent, educational decisionmaker, foster parent, court representative, and teachers of the child.

(ii) INFORMATION AND FACTORS.—The information and factors described in clause (i) shall include—

(I) the harmful impact of school mobility on the child's academic progress, achievement, and social and emotional well-being;

(II) the age of the child;

(III) the impact the commute to school may have on the child's education or well-being;

(IV) personal safety issues, including safety as it relates to family violence;

(V) the child's need for special instruction, including special education and related services, and where those needs can best be met;

(VI) the length of stay in foster care, placement type, and permanency plan for the child;

(VII) the time remaining in the school year;

(VIII) the school placement of family members;

(IX) the number of previous school changes;

(X) the child's connection to the school of origin under consideration;

(XI) the extent to which the educational program of the school of origin is appropriate, meets the child's needs and interests, and nurtures the child's talents; and

(XII) the availability of special programs, academically rigorous courses, and extracurricular activities that are appropriate for the child.

(F) CONSIDERATIONS.—An entity making a school selection decision under this paragraph shall consider the wishes of the child.

(G) EXCLUDED FACTORS.—The cost of transportation to or from a school shall not be a consideration when making a school selection decision.

(H) TRANSPORTATION.—

(i) IN GENERAL.—The local educational agency serving the school of origin in which a child in foster care shall remain or enroll, based on the school selection decision for the child, shall collaborate with the local child welfare agency to ensure that the child is provided transportation to the school of origin in a cost effective manner and in accordance with section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)).

(ii) COST OF TRANSPORTATION.—In carrying out clause (i), a local educational agency shall provide the transportation described in such clause for a child in foster care if—

(I) the local child welfare agency reimburses the local educational agency for the cost of such transportation, in accordance with section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II));

(II) the local educational agency agrees to pay for the cost of such transportation; or

(III) the local educational agency and the local child welfare agency agree to share the cost of such transportation.

(5) SCHOOL SELECTION DECISION DISPUTE RESOLUTION.—

(A) IN GENERAL.—The State educational agency, or another State agency designated by the State, shall develop and oversee a fair and impartial dispute resolution procedure to promptly resolve school selection decision disputes, except that such procedure shall not be applied to disputes regarding school selection decisions made by a court.

(B) COMPONENTS OF DISPUTE RESOLUTION.—The dispute resolution procedure described in subparagraph (A) shall include, at a minimum—

(i) a procedural safeguard system to resolve disputes and render prompt school selection decisions;

(ii) written notice of the school selection decision and basis for the decision to the—

(I) parent, education decisionmaker, and court representative of the child; and

(II) local child welfare agency serving the child;

(iii) a right to appeal a school selection decision, an impartial and prompt review of such decision, and a written determination of the administrative appeal; and

(iv) a right to initiate a dispute under this paragraph that is provided to—

(I) the parent, education decisionmaker, and court representative of the child; and

(II) a representative from the local child welfare agency or local educational agency serving the child.

(C) SCHOOL PLACEMENT DURING DISPUTE.—If a dispute arises over the school selection decision, the child shall remain in the child's current school until full resolution of the dispute, unless—

(i) the dependency court determines otherwise and selects a different school for the child; or

(ii) the State child welfare agency or local child welfare agency with responsibility for the child determines that the child's health or safety would be at risk if the child remained in such school prior to a determination made under subparagraph (A) and selects a different school for the child.

(D) TRANSPORTATION.—In the case of a dispute under this paragraph regarding a child in foster care, the local educational agency where the child is attending school pending the resolution of the dispute, as determined under subparagraph (C), shall collaborate with the local child welfare agency to ensure transportation is provided, as required under section 101(a)(6), for the child to such school, until the full resolution of the dispute in accordance with this paragraph.

(6) COMPLAINT MANAGEMENT SYSTEM.—Each State shall maintain a complaint management system by which individuals and organizations acting on behalf of a child in foster care can request that the State investigate and correct violations of this subtitle in a timely manner on behalf of a child in foster care or a group of children in foster care.

(7) SCHOOL READINESS FOR CHILDREN IN FOSTER CARE.—

(A) STATE AND LOCAL EDUCATIONAL AGENCIES.—Each State educational agency and local educational agency shall ensure that public preschool programs funded, administered, or overseen by such agency—

(i) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment for the child is sought, unless otherwise required by State law;

(ii) identify and prioritize preschool-aged children in foster care for enrollment and increase such children's enrollment and attendance in the public preschool program, through activities such as—

(I) reserving spaces in public preschool programs for children in foster care;

(II) conducting targeted outreach to local child welfare agencies and foster care providers;

(III) waiving application deadlines;

(IV) providing ongoing professional development for staff regarding the needs of children in foster care and their families and strategies to serve such children and families; and

(V) developing capacity to serve all children in foster care in the area served by such agency; and

(iii) review the educational and related needs of children in foster care and their families in such agencies' service areas, in coordination with the State child welfare agency, the local child welfare agency, and the foster care liaison designated under paragraph (3), and develop policies and practices to meet identified needs.

(B) OTHER STATE AGENCIES.—In the case of public preschool programs that are not funded, administered, or overseen by the State educational agency or a local educational agency, the State agency that funds such public preschool programs shall—

(i) develop, review, and revise its policies and practices to remove barriers to the enrollment, attendance, retention, and success of children in foster care in public preschool programs funded, administered, or overseen by the agency;

(ii) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs—

(I) shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment is sought for the child, unless otherwise required by State law;

(II) shall not be subject to the dispute resolution procedures of the State educational agency or local educational agencies, but shall—

(aa) ensure that all of the dispute resolution procedures available through such programs and the State agency that funds, administers, or oversees such programs are accessible to the education decisionmaker, court representative of a child in foster care, and a representative from the local child welfare agency; and

(bb) provide such individuals with a written explanation of their dispute and appeal rights; and

(III) shall not be subject to the transportation requirements of paragraph (5)(D) and subsection (a)(6), but shall remove barriers to existing transportation services for children in foster care and shall, to the maximum extent practicable, arrange or provide transportation for children in foster care to attend public preschool programs, including the children's school of origin;

(iii) identify and prioritize children in foster care for enrollment and increase such children's enrollment and attendance in public preschool programs, including through activities described in subclauses (I) through (V) of subparagraph (A)(ii); and

(iv) review the educational and related needs of children in foster care and the children's families in the State, in coordination with the coordinator described in paragraph (2), and develop policies and practices to meet identified needs.

(C) SCHOOL OF ORIGIN.—For the purposes of applying this paragraph, a reference to a school shall be deemed to include a public preschool program.

(8) SHARING INFORMATION.—

(A) IN GENERAL.—The State educational agency and local educational agency shall

review and eliminate any barriers to information-sharing with State child welfare agencies and local child welfare agencies, while continuing to protect the privacy interests of children and families, as required by Federal or State law.

(B) IMMEDIATE AVAILABILITY.—To ensure a child in foster care's immediate enrollment in a new school (including a preschool program), all education records of the child shall be made available in accordance with subsection (a)(4). A school sending education records shall ensure that the records are as complete and accurate as possible.

(C) COMPLIANCE WITH FERPA.—Education records of a child in foster care shall be—

(i) maintained and provided to other schools in a manner consistent with section 444 of the General Education Provisions Act (commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g); and

(ii) provided to the child welfare agency or other child welfare system advocates in a manner that complies with such section.

(D) EXPEDITED TRANSFER.—Each foster care liaison described in paragraph (3) and coordinator described in paragraph (2) within a State shall work to expedite the transfer of education records of children in foster care.

(9) TRANSFER OF CREDITS; DIPLOMA.—

(A) TRANSFER OF CREDITS.—The State shall have a system for ensuring that—

(i) a child in foster care who is changing schools can transfer school credits and receive partial credits for coursework satisfactorily completed while attending a prior school or educational program; and

(ii) a child in foster care is afforded opportunities to recover school credits lost due to placement instability while in foster care.

(B) ELIMINATING BARRIERS.—The State shall undertake steps to eliminate barriers to allowing a child in foster care who has experienced multiple school placements to receive a secondary school diploma either from one of the school districts in which the student was enrolled or through a State-issued secondary school diploma system.

(10) EQUAL ACCESS.—

(A) IN GENERAL.—The State and each local educational agency of the State shall take steps to eliminate barriers to access for children in foster care to academic, nonacademic, or extracurricular programs that are created by application or entrance deadlines and other admissions requirements that children in foster care cannot meet because of frequent school changes.

(B) NO FORCED PRIVATE PLACEMENT.—The State shall ensure that each group home or placement facility in the State in which a child in foster care may be placed does not explicitly or implicitly condition such placement on attendance at a private school owned or operated by an agency associated with the facility.

(C) NO SCHOOL SEGREGATION.—The State shall ensure that a child in foster care, including a child residing in a group home or placement facility—

(i) shall not be educated in a segregated setting due to the child's status as a child in foster care; and

(ii) shall have access to—

(I) a public elementary school or secondary school; or

(II) in the case of a child with an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414), an alternative setting, if required under such plan.

(11) COLLABORATION IN DEVELOPING CHILD-SPECIFIC CASE PLANS.—

(A) IN GENERAL.—Each local educational agency of the State shall collaborate, at the local child welfare agency's request, with the local child welfare agency with respect to the following to ensure that educational issues for children in foster care are appropriately identified and addressed:

(i) The development of the following components of the case plan required for children in foster care:

(I) The written description of the programs and services which will help the child prepare for the transition from foster care to independent living required under subparagraph (D) of section 475(1) of the Social Security Act (42 U.S.C. 675(1)).

(II) The plan for ensuring the educational stability of the child while in foster care required under subparagraph (G) of section 475(1) of the Social Security Act (42 U.S.C. 675(1)).

(ii) The requirement under subparagraph (H) of section 475(5) of the Social Security Act (42 U.S.C. 675(5)) to provide a child in foster care with assistance and support in developing a transition plan for aging out of foster care to independent living.

(iii) The programs and activities, including vouchers for education and training, including postsecondary training and education, for youths who have aged out of foster care, carried out under the John H. Chafee Foster Care Independence Program established under section 477 of the Social Security Act (42 U.S.C. 677).

(iv) All other child welfare agency-based planning that relate to educational issues for a child in foster care or a child transitioning out of foster care to independent living.

(B) CONTENTS.—The local child welfare agency shall specify in the case plan required for children in foster care under parts B and E of title IV of the Social Security Act the local educational agency's role in providing guidance, information, and support to implement the education-related provisions of the plan.

(C) LOCAL EDUCATIONAL AGENCY ROLE.—Each local educational agency of the State shall—

(i) cooperate with the implementation of programs, activities, services, and vouchers described in subparagraph (A); and

(ii) ensure that such programs, activities, services, and vouchers are coordinated with any education plans developed by the local educational agency, including, when appropriate, any plan for transition services for a child in foster care that is included in the child's individualized education program, as required under section 614(d) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)).

(12) COLLECTING INFORMATION.—

(A) IN GENERAL.—The State shall collect valid and reliable information as needed to report annually to the Secretary on the State's progress in meeting the requirements of this title. Such report shall include, at a minimum—

(i) the number of children in foster care enrolled in school and in public preschool programs;

(ii) the number of such children who remained in the child's school of origin;

(iii) the number of such children who experienced enrollment delays;

(iv) State assessment scores disaggregated for children in foster care;

(v) secondary school graduation rates, including on-time graduation rates, for such children;

(vi) the number of such children who repeated grades; and

(vii) the number of such children who—

(I) are eligible for special education and related services; or

(II) receive services under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.).

(B) INFORMATION SHARING.—The State educational agency and local educational agencies shall collaborate with the State child welfare agency and local child welfare agencies to collect and share necessary information in order to generate such reports.

(c) COLLABORATION.—To carry out this section, each State educational agency and the local educational agencies of a recipient State shall collaborate with the State child welfare agency and local child welfare agencies of such State.

SEC. 102. REMEDIES; RULE OF CONSTRUCTION.

(a) JUDICIAL REMEDIES.—

(1) IN GENERAL.—Any party aggrieved by a finding or decision made under paragraph (5) or (6) of section 101(b), or who otherwise claims that a right provided under this Act has been violated, may bring a civil action in an appropriate district court of the United States.

(2) JURISDICTION.—The district courts of the United States shall have jurisdiction of actions brought under this title without regard to the amount in controversy.

(3) ATTORNEY'S FEES.—In any action or proceeding brought under paragraph (1), the court, in its discretion, may award reasonable attorney's fees and expert witness fees as part of costs to a prevailing party who is acting on behalf of a child in foster care.

(4) STATE SOVEREIGN IMMUNITY.—

(A) IN GENERAL.—A recipient State's receipt or use of funds under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) shall constitute a waiver of sovereign immunity, under the 11th amendment to the Constitution or otherwise, to a civil action brought under paragraph (1).

(B) EFFECTIVE DATE.—This paragraph shall apply with respect to violations that occur in whole or in part after the effective date of this Act.

(C) REMEDIES.—In a civil action against a State for a violation of this paragraph, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as those remedies are available for such a violation in the civil action against any public entity other than a State.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under—

(1) the Constitution;

(2) the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11461 et seq.);

(3) the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–315), or the amendments made by such Act;

(4) section 444 of the General Education Provisions Act (commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g);

(5) the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.); or

(6) any other Federal or State law protecting the rights of children in foster care.

SEC. 103. CONFORMING AMENDMENTS.

The Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) is amended—

(1) in section 1111 (20 U.S.C. 6311)—

(A) in subsection (b)(2), by adding after subparagraph (K) the following:

''(L) ACCOUNTABILITY FOR CHILDREN IN FOSTER CARE.—The accountability provisions under this Act shall ensure that children in foster care, as defined in section 4 of the Fostering Success in Education Act, are included in academic assessment, reporting, and accountability systems, in accordance with paragraph (3)(C)(xi).''; and

(B) in subsection (c)—

(i) in paragraph (13), by striking ''and'' at the end;

(ii) in paragraph (14), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(15) the State and State educational agency will ensure that the requirements of section 101 of the Fostering Success in Education Act will be satisfied.''; and

(2) in section 1112(c)(1) (20 U.S.C. 6312(c)(1))—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(P) comply with the requirements of section 101 of the Fostering Success in Education Act that relate to the local educational agency.''.

Subtitle B—State Foster Care and Education Plan Grants

SEC. 111. STATE FOSTER CARE AND EDUCATION PLAN REQUIREMENTS AND GRANTS.

(a) GENERAL AUTHORITY.—From amounts appropriated to carry out this subtitle and not reserved under subsection (b)(2), the Secretary shall make grants to States, from allotments under subsection (b)(1), to enable the States to carry out activities, and award subgrants, in accordance with subsection (d).

(b) ALLOTMENTS AND RESERVATION.—

(1) ALLOTMENTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary is authorized to make an allotment to each State with an approved State foster care and education plan under subsection (c) for a fiscal year in an amount that bears the same relation to the total amount available under this paragraph for a fiscal year as the number of children in foster care who reside in the State bears to the total number of children in foster care who reside in all States with approved State foster care and education plans.

(B) MINIMUM ALLOTMENTS.—The amount of a State's allotment under this paragraph for a fiscal year shall not be less than $300,000.

(C) RATABLE REDUCTIONS.—In the case of a fiscal year for which the amounts available to carry out this subtitle are not sufficient to award grants to States in the amounts described in subparagraphs (A) and (B), the Secretary shall ratably reduce the amount of all such grants.

(2) RESERVATIONS.—

(A) RESERVATION FOR TECHNICAL ASSISTANCE AND EVALUATION.—Of the funds made available to carry out this section, the Secretary shall reserve 1 percent of such funds to provide—

(i) technical assistance to States that receive grants under this subtitle; and

(ii) rigorous evaluation of the activities funded with grants under this subtitle in accordance with section 113.

(B) STUDENTS IN TERRITORIES.—Of the funds made available to carry out this section, the Secretary shall reserve 0.10 percent of such funds to be allocated among the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, according to their respective need for assistance under this subtitle, as determined by the Secretary.

(C) INDIAN STUDENTS.—Of the funds made available to carry out this section, the Secretary shall reserve 1.0 percent to provide assistance to the Secretary of the Interior for programs that are for Indian children in foster care who are served by schools funded by the Department of Interior and that are consistent with the purposes of the activities described in this subtitle.

(c) STATE FOSTER CARE AND EDUCATION PLAN.—

(1) ELIGIBILITY REQUIREMENT.—No State shall receive a grant under this subtitle unless the State educational agency has submitted to the Secretary, and the Secretary has approved under section 113(a)(1), a State foster care and education plan (referred to in this section as the ''plan'') that—

(A) includes the information described in paragraph (3); and

(B) describes the specific responsibilities and procedures undertaken by each applicable agency of the State to meet the requirements of subsections (e) and (f) and subtitle A.

(2) APPROVAL, REVIEW, AND RESUBMISSION.—

(A) DEVELOPMENT AND APPROVAL.—The plan for a State shall be—

(i) developed by the State educational agency, in collaboration with the State child welfare agency; and

(ii) approved by the chief executive officer of the State before submission to the Secretary.

(B) ANNUAL REVIEW.—Each State receiving a grant under this subtitle shall review the plan annually, in collaboration with the State child welfare agency and the State educational agency, to determine the State's compliance with the plan, including a review of the—

(i) information collected under section 101(b)(12); and

(ii) the State's progress in eliminating barriers identified under paragraph (3)(B).

(C) RESUBMISSION.—Each State receiving a grant under this subtitle shall resubmit the plan, with amendments as necessary, after collaboration with the State child welfare agency and approval by the chief State official in charge of the State's child welfare system, every 3 years for review and approval by the Secretary.

(3) PLAN CONTENTS.—The plan shall address how each right and requirement under section 101 will be achieved, including—

(A) the method by which the State will monitor local educational agencies and other local agencies with responsibility under this title to ensure compliance with this title;

(B) an analysis of the State and local barriers to meeting the requirements of this title, including the barriers described in paragraphs (8), (9)(B), and (10) of section 101(b), and specific steps taken to eliminate those barriers;

(C) a description of, and protocol for, how State foster care coordinators described in section 101(b)(2) and foster care liaisons described in section 101(b)(3) will work collaboratively with State child welfare agencies and local child welfare agencies to implement the provisions of this title;

(D) detailed procedures for making the school selection decisions for children in foster care in the State in accordance with section 101(b)(4);

(E) clear procedures regarding how transportation to maintain each child in foster care in the appropriate school will be provided, arranged, and funded;

(F) an explanation of how the State will—

(i) ensure transfers of school credits and partial credits for children in foster care who experience multiple school moves; and

(ii) eliminate barriers to allowing such children to obtain secondary school diplomas as required under section 101(b)(4);

(G) an explanation of how the State will put in place a procedural safeguard system that meets the requirements of section 101(b) and protects the rights of children in foster care, as described in section 101(a), and how such system will—

(i) operate;

(ii) resolve disputes about school stability, immediate enrollment, and eligibility for services under the title;

(iii) provide notice to children in foster care, and the parents, educational decision makers, and court representatives, of the rights of children under section 101(a) and the processes for obtaining a school selection decision for the child and for resolving disputes under section 101(b); and

(iv) protect the child's rights under section 101(a) during the resolution of any disputes;

(H) a description of how the State has involved, and will continue to involve, individuals representing all critical stakeholders involved with children in foster care, including children in foster care, parents, education decisionmakers, foster parents and other caretakers, caseworkers, court representatives, and judges, in the development of the plan and when making decisions about policies and procedures to implement this title;

(I) a description of how training needs relating to children in foster care will be identified and addressed for—

(i) critical stakeholders in the State educational agency, local educational agencies, the State child welfare agency, and local child welfare agencies; and

(ii) other necessary parties involved with children in foster care;

(J) a description of how local educational agencies in the State, in collaboration with local child welfare agencies, will meet the requirements of subsection (f), section 101(b)(1), and other provisions in this title relating to local educational agencies;

(K) a description of services or policies needed for children in foster care to meet the same challenging student academic achievement standards under section 1111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) to which other children are held, and a description of the steps that will be taken to create and implement those services or policies;

(L) a description of all efforts to promote efficient record maintenance and sharing to further the purposes of this title while protecting confidentiality rights under section 444 of the General Education Provisions Act (commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g) and other laws;

(M) a description of how immediate enrollment for children in foster care, as required under section 101(a)(3), will be achieved, including how any record requirements in effect as of the date of the plan will be addressed so as to not delay enrollment;

(N) a description of the system that will ensure the timely transfer of education and health records of children in foster care and an explanation of how any delay in such transfer will not interfere with immediate enrollment; and

(O) procedures for periodically monitoring local educational agency compliance with the requirements of this title and for maintaining a complaint management system as required under section 101(b)(12).

(d) USE OF FUNDS.—A State receiving an allotment under this subtitle shall use—

(1) not more than 25 percent of the State's allotment to carry out the State plan under subsection (c), meet the requirements under subsections (e) and (f), and carry out activities, directly or through grants or contracts, to further the purposes of this title; and

(2) not less than 75 percent of the State's allotment to award subgrants under section 112.

(e) STATE REQUIREMENTS.—

(1) STATE EDUCATIONAL AGENCY ROLE.—

(A) IN GENERAL.—The State educational agency of a State receiving a grant under this subtitle shall be responsible for—

(i) the general administration and supervision of programs and activities receiving funds under this subtitle, including the activities described in paragraph (2) and subgrants awarded under section 112;

(ii) monitoring programs and activities used by the State to carry out this title, whether or not such programs or activities

are receiving assistance under this subtitle; and

(iii) ensuring that the State is in compliance with the requirements under this title.

(B) COLLABORATION.—A State educational agency shall collaborate with the State child welfare agency in carrying out the responsibilities under this paragraph.

(2) ACTIVITIES.—Each State receiving a grant under this subtitle shall carry out the following activities:

(A) STAKEHOLDER COUNCIL.—

(i) IN GENERAL.—The State educational agency shall establish a Stakeholder Council (referred to in this paragraph as the ''Council'') that meets publicly on not less than a semiannual basis.

(ii) MEMBERSHIP.—The members of the Council shall include, at a minimum—

(I) a designee from the State educational agency;

(II) a designee from the State child welfare agency; and

(III) individuals representing local educational agencies, local child welfare agencies, juvenile courts, court representatives, court appointed special advocates, children in foster care, foster parents, and parents.

(iii) DUTIES.—The Council shall—

(I) review the State's policies, practices, data, and other information regarding the implementation of this title;

(II) review and advise the State on the plan before the plan's submission or resubmission;

(III) make recommendations regarding procedures and policies for implementing this title;

(IV) assess progress towards eliminating identified barriers to compliance that are described in subsection (c)(3)(B);

(V) prepare and submit an annual report to the State educational agency, the State child welfare agency, any other applicable State agency, and the Secretary on the status of implementation efforts, including an analysis of data collected; and

(VI) make recommendations regarding the next steps the State should take regarding implementation and submit such recommendations to the Secretary with each plan resubmission under subsection (c)(2)(C).

(B) MONITORING.—The State educational agency, in collaboration with the State child welfare agency, shall periodically monitor local educational agencies and other local agencies with responsibilities under this title to ensure compliance.

(f) LOCAL EDUCATIONAL AGENCY REQUIREMENTS.—Each local educational agency in a State receiving a grant under this subtitle shall meet the following requirements:

(1) IN GENERAL.—The local educational agency shall ensure, in coordination with the corresponding local child welfare agency, that children in foster care in the school district served by the local educational agency receive all of the rights described in section 101(a) by carrying out, at a minimum, all of the following:

(A) Ensuring that each child in foster care in the school district served by the local educational agency remains in a school of origin or is immediately enrolled in a new school, in accordance with the child's best interest as required under section 101(a).

(B) Documenting that written notice has been provided to the parent, education decisionmaker, and court representative of the child and the local child welfare agency representative responsible for the child with regard to any decisions made by the local educational agency regarding the rights under this title of a child in foster care, including—

(i) an explanation of the basis for the decision;

(ii) the right to appeal the decision; and

(iii) the right of the child to remain in the child's current school while a dispute is pending.

(C) Ensuring compliance with this title by all schools served by the local educational agency.

(D) Identifying and removing any barriers that exist in schools served by the local educational agency, including—

(i) barriers identified in the plan under subsection (b)(3)(B);

(ii) barriers to remaining or enrolling in a school of origin, or to enrolling promptly in a new school for a child in foster care if such enrollment is in the child's best interest; or

(iii) other barriers impeding the rights of a child in foster care under this title.

(E) Ensuring that the schools served by the local educational agency promptly transfer the school credits and partial school credits of children in foster care, and provide children in foster care with access to credit recovery programs or services.

SEC. 112. SUBGRANTS.

(a) IN GENERAL.—The State educational agency shall, in accordance with section 111(b)(2), award subgrants, on a competitive basis, to public agencies, including local educational agencies and local child welfare agencies, or partnerships comprised of public agencies, to carry out the requirements of this title or clause (ii)(II), (iii), or (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)).

(b) APPLICATION.—A public agency, or a partnership of public agencies, desiring a subgrant under this section shall submit an application to the State educational agency at such time, in such manner, and containing such information as the State educational agency may require.

(c) AWARD BASIS.—

(1) IN GENERAL.—The State educational agency shall award subgrants under this section based on—

(A) the established need for attention to the education of children in foster care in the area served by the public agency or partnership of public agencies; and

(B) the quality of activities proposed to address such need by the agency or partnership in the application described in subsection (b).

(2) PRIORITY.—In awarding subgrants under this section, the State educational agency shall give priority to the following applicants:

(A) Local child welfare agencies that have entered into agreements with local educational agencies to share responsibilities for providing, arranging, and paying for the transportation of children in foster care to the children's school of origin in a cost-effective manner.

(B) Local educational agencies that have entered into such agreements with local child welfare agencies.

(C) Partnerships that—

(i) include not less than 1 local child welfare agency and not less than 1 local educational agency; and

(ii) have entered into such agreements.

(d) USE OF FUNDS.—A public agency, or a partnership of public agencies, receiving a subgrant under this section shall use subgrant funds to assist the State educational agency providing the subgrant in meeting the State's responsibilities under this title or clause (ii)(II), (iii), or (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)), which assistance may include—

(1) funding of foster care liaison positions, as described in section 101(b)(3), at the local educational agency;

(2) coordinating activities that support the purposes of this title between local educational agencies, local child welfare agencies, and other relevant agencies;

(3) expenditures for transportation costs;

(4) tutoring or other educational support services specifically targeted to children in foster care;

(5) expediting special education evaluations for children in foster care;

(6) pupil activities and services needed to promote school and preschool success for children in foster care;

(7) training for the staff of the State educational agency, the local educational agencies, the State child welfare agency, and the local child welfare agencies, and for children in foster care, such children's families, and others involved with children in foster care, about—

(A) the unique educational needs of children in foster care;

(B) the benefits afforded under this title; and

(C) other issues that further the purposes of this title; and

(8) assisting in funding State-level education coordinators in the State child welfare agency and local education liaisons within the local child welfare agency to be specific points of contact on education issues.

SEC. 113. RESPONSIBILITIES OF THE SECRETARY.

(a) REVIEW OF STATE PLANS.—

(1) IN GENERAL.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall review the plan submitted or resubmitted by a State under section 111(c). If the plan meets the requirements of section 111 and is reasonably calculated to ensure that all children in foster care in the State receive all rights, benefits, and protections required by this title, the Secretary shall approve the plan.

(2) DISAPPROVAL.—

(A) IN GENERAL.—If a plan does not meet the requirements described in paragraph (1), the Secretary shall disapprove the plan and provide the State educational agency with specific findings as to what needs to be corrected for approval.

(B) REVIEW PROCESS.—The Secretary shall promulgate regulations establishing a system by which States whose plans are disapproved can appeal such disapproval.

(b) TECHNICAL ASSISTANCE.—The Secretary shall provide—

(1) training, support, and technical assistance to a State educational agency receiving a grant to assist the State educational agency in carrying out its responsibilities under this title; and

(2) training, support, and technical assistance to a State that has had the State's plan described in section 111 disapproved.

(c) SUBMISSION AND DISTRIBUTION.—The Secretary shall—

(1) require applications for grants under this subtitle to be submitted to the Secretary not later than the expiration of the 60-day period beginning on the date that funds are available for purposes of making such grants; and

(2) award such grants not later than the expiration of the 120-day period beginning on such date.

(d) DETERMINATION BY SECRETARY.—The Secretary, based on the information received from the States and information gathered by the Secretary under this subtitle and under section 101(b)(11), shall determine the extent to which State educational agencies are ensuring that each child in foster care has access to a free, appropriate public education.

(e) INFORMATION.—

(1) COORDINATION; ENFORCEMENT.—The Secretary shall coordinate and enforce the information collection requirements under this subtitle and section 101(b)(12).

(2) DATA COLLECTION AND DISSEMINATION.—The Secretary shall—

(A) directly or through grants, contracts, or cooperative agreements, periodically collect and disseminate data and information regarding the education of children in foster care; and

(B) require each State receiving a grant under this subtitle to annually provide—

(i) the information described in section 101(b)(12)(A); and

(ii) such other data and information as the Secretary determines to be necessary and relevant to carry out this subtitle.

(f) EVALUATION AND DISSEMINATION.—The Secretary shall conduct evaluation and dissemination activities regarding programs designed to meet the educational needs of elementary and secondary school students who are children in foster care.

(g) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary shall prepare and submit to the Committee on Education and Labor and the Committee on Ways and Means of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate a report on the status of the education of children in foster care, which shall include information on—

(1) the educational outcomes of children in foster care; and

(2) the actions of the Secretary and the effectiveness of the programs supported under this title.

SEC. 114. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out the subtitle, $150,000,000 for each of the fiscal years 2011 through 2015.

TITLE II—SOCIAL SECURITY ACT AMENDMENTS

SEC. 201. SOCIAL SECURITY ACT AMENDMENTS.

(a) EDUCATIONAL STABILITY FOR FOSTER CARE CHILDREN.—Section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) is amended—

(1) in clause (ii)—

(A) by striking ''or'' at the end of subclause (I) and inserting ''and''; and

(B) by striking subclause (II), and inserting the following:

''(II) assurances that the State agency has coordinated with the appropriate local educational agency to ensure that the child remains in the school in which the child is enrolled at the time of placement including, when necessary, the State agency arranging for, providing, or paying the cost of the transportation necessary to enable the child to remain in the school;''; and

(2) by adding at the end the following:

''(iii) assurances by the State agency and the local educational agencies, if remaining in such school is not in the best interests of the child, to provide immediate and appropriate enrollment in a new school, with all of the educational records provided to the school; and

''(iv) assurances by the State agency and local child welfare agencies that steps have been undertaken to collaborate with the State and local educational agencies to eliminate barriers to the educational stability, school enrollment, and educational success of the child.''.

(b) STATE PLAN REQUIREMENT.—Section 471 of the Social Security Act (42 U.S.C. 671(a)) is amended—

(1) in paragraph (32), by striking ''and'' after the semicolon;

(2) in paragraph (33), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(34) provides that the State agency and local child welfare agencies will collaborate with the State and local educational agencies to collect the data and other information necessary to monitor implementation of the requirements of clauses (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1) and the provisions of section 101 of the Fostering Success in Education Act; and

''(35) provides that the State agency and local child welfare agencies have identified staff within the agencies to be the point people with the State and local educational agencies related to educational issues, including the implementation of the requirements of clauses (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1), as well as to coordinate with educational agency liaisons and coordinators to implement the provisions of section 101 of the Fostering Success in Education Act.''.

By Mr. SPECTER:

S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SPECTER. Mr. President, I seek recognition to introduce legislation to deal with the pressing problem of hunger in the United States. The report of the Economic Research Service of the Department of Agriculture on Monday, November 16—3 days ago—disclosed some startling facts about hunger in America. The report showed there are 49 million Americans who experienced hunger last year. Among that number, 17 million were children, and 500,000 of those children were under the age of 6, which is a critical stage in childhood development.

The hunger problem hit disproportionately higher for Hispanics at 27 percent higher and African Americans at 26 percent higher. It is hard to find a sufficiently tough word to describe it—scandalous, outrageous, criminal, repugnant—that in this land of plenty, we should find Americans who are hungry. It is unacceptable to have people hungry anywhere in the world, but right here in our own backyard for this situation to exist is beyond the pale.

Having read the article on the 16th, I contacted the Secretary of Agriculture, Tom Vilsack, discussed the issue with him, and I am now introducing legislation which will add $250 million to the food banks to try to deal with this issue on an emergency basis. It would be my hope that this is the kind of legislation which could be passed very promptly—hopefully, before Christmas of this year during our current session—to take some immediate action to replenish the food banks so people in America are not hungry.

Mr. President, I ask unanimous consent that my full statement be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SENATOR ARLEN SPECTER—STATEMENT ON THE INTRODUCTION OF LEGISLATION PROVIDING FOR EMERGENCY FOOD RELIEF

Mr. SPECTER. Mr. President, I have sought recognition to introduce legislation addressing our nation's hunger crisis. The United States Department of Agriculture just released its annual report on Household Food Security in the United States. This report finds that 49 million Americans, 17 million of whom are children, experienced food insecurity and hunger in 2008. Poverty is the underlying cause of this problem. While job creation policies to lift these Americans out of poverty are being implemented, Congress must provide immediate relief so that they have access to the nutrition necessary to live a healthful and productive life.

The USDA report contains alarming data on the struggles faced by too many American families. In 2008, 17 million households reported being food insecure, that is to say they lacked access to enough food for an active and healthy life. This is an increase from 13 million households in 2007. In my state of Pennsylvania, 11.2 percent of our 4,970,000 households reported being food insecure, and 4.2 percent reported very low food security, meaning they were unable to eat at various times over the year.

Of these 49 million Americans who reported hunger, 12 million adults and 5.2 million children reported periods of extreme hunger, possibly going days without eating. The data shows that black and Hispanic households experienced food insecurity at rates far higher than the national average at 26 percent and 27 percent respectively.

Among the 17 million children, nearly half a million under the age of 6 were hungry. This is a critical stage of childhood development that is being undermined by a lack of access to proper nutrition, which is necessary for learning and academic achievement.

Fortunately, Congress has taken steps to address this important issue, appropriating for fiscal year 2010 $9.2 billion for the School Lunch Program and $171 million for the Commodity Supplemental Food Program which provides nutrition assistance to mothers, children and the elderly. The economic stimulus package contained more than $20 billion for nutrition assistance. Yet, this USDA study shows us that more is needed.

That is why I am introducing legislation to double spending on The Emergency Food Assistance Program, or TEFAP, from $250 to $500 million annually. Through TEFAP, the USDA makes commodity and food purchases and then distributes nutrition assistance to states based on need. The numbers show us there is great need.

According to Feeding America, which operates 205 food banks nationwide and 10 in the Commonwealth of Pennsylvania, 99 percent of their food banks experienced an increase in demand during the month of September 2009 and 91 percent of food banks reported unemployment as a critical factor driving the increase in emergency food assistance. Unfortunately 51 percent of these food banks had to turn someone away in the last year. By doubling TEFAP spending, Congress would significantly increase the amount of food being delivered to local food banks, ensuring that less Americans go hungry.

According to the Department of Agriculture, nearly 27 percent of the 356 billion pounds of available food in America is wasted each year. That is nearly 100 billion pounds of waste, when according the charity Feeding America only 5 billion pounds of food is needed to eliminate hunger. In a country with such a food abundance, it is criminal that children to go to bed hungry. Our country has a developed network of food assistance providers in place. Government agencies, community food banks, food pantries, soup kitchens, shelters and churches all stand ready to address the challenge of combating hunger. Let us provide them the resources they need. The legislation I am introducing today will do that and will stem the tide of hunger.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2805

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

SECTION 1. FINDINGS.

Congress finds that—

(1) more than 1 in 7 households in the United States struggled to find enough to eat during 2008;

(2) poverty is the primary cause of food insecurity and hunger in the United States;

(3) the annual report of the Economic Research Service of the Department of Agriculture on household food security in the United States found that in 2008, 17,000,000 households were food insecure, an increase from 13,000,000 households in 2007;

(4) the term ''low food security'' means people being unable to consistently get enough to eat and the term ''very low food security'' means people being hungry at various times over the year and being unable to eat because of lack of money to purchase food;

(5) the 17,000,000 food insecure households in the United States are home to 49,000,000 Americans, of whom—

(A) 17,000,000 are children, among whom nearly 500,000 in the developmentally critical years under the age of 6 are going hungry; and

(B) 12,000,000 adults and 5,200,000 children reported experiencing severe hunger, possibly going days without eating;

(6) good nutrition is necessary for learning and academic achievement; and

(7) Black and Hispanic households experienced food insecurity at far higher rates (25.7 percent in the case of Black households and 26.9 percent in the case of Hispanic households) than the national average.

SEC. 2. AVAILABILITY OF COMMODITIES FOR THE EMERGENCY FOOD ASSISTANCE PROGRAM.

Section 27(a)(2) of the Food and Nutrition Act of 2009 (7 U.S.C. 2036(a)(2)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) by redesignating subparagraph (C) as subparagraph (E);

(3) in subparagraph (E) (as so redesignated)—

(A) by striking ''each of fiscal years 2010 through 2012'' and inserting ''fiscal year 2012''; and

(B) by striking ''subparagraph (B)'' and inserting ''subparagraph (D)''; and

(4) by inserting after subparagraph (B) the following:

''(C) for fiscal year 2010, $500,000,000;

''(D) for fiscal year 2011, $250,000,000, as adjusted in accordance with subparagraph (E); and''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 355—EXPRESSING THE SENSE OF THE SENATE THAT THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF IRAN HAS SYSTEMATICALLY VIOLATED ITS OBLIGATIONS TO UPHOLD HUMAN RIGHTS PROVIDED FOR UNDER ITS CONSTITUTION AND INTERNATIONAL LAW

Mr. LEVIN (for himself, Mr. MCCAIN, Mr. CASEY, Mr. GRAHAM, Mr. LIEBERMAN, Mr. CORKER, and Mr. NELSON of Florida) submitted the following resolution; which was considered and agreed to:

S. RES. 355

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which its ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women's rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary arrest, indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one's faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja'far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran jailed Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women's rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Nations High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Iranian Journalists in August 2009, the country's largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used brutal force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations;

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including artists and filmmakers since the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani,

human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning: Now, therefore, be it

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(2) condemns the Government of Iran's human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory;

(4) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhumane, or degrading treatment;

(6) calls for the Government of Iran to ensure those currently in detention are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the ''freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in print, in the form of art, or through any other media of his choice''.

SENATE RESOLUTION 356—CALLING UPON THE GOVERNMENT OF TURKEY TO FACILITATE THE REOPENING OF THE ECUMENICAL PATRIARCHATE'S THEOLOGICAL SCHOOL OF HALKI WITHOUT CONDITION OR FURTHER DELAY

Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 356

Whereas the Ecumenical Patriarchate is an institution with a history spanning 17 centuries, serving as the center of the Orthodox Christian Church throughout the world;

Whereas the Ecumenical Patriarchate sits at the crossroads of East and West, offering a unique perspective on the religions and cultures of the world;

Whereas the title of Ecumenical Patriarch was formally accorded to the Archbishop of Constantinople by a synod convened in Constantinople during the sixth century;

Whereas since November 1991, His All Holiness, Bartholomew I, has served as Archbishop of Constantinople, New Rome and Ecumenical Patriarch;

Whereas Ecumenical Patriarch Bartholomew I was awarded the Congressional Gold Medal in 1997, in recognition of his outstanding and enduring contributions toward religious understanding and peace;

Whereas during the 110th Congress, 75 Senators and the overwhelming majority of members of the Committee on Foreign Affairs of the House of Representatives wrote to President George W. Bush and the Prime Minister of Turkey to express congressional concern, which continues today, regarding the absence of religious freedom for Ecumenical Patriarch Bartholomew I in the areas of church-controlled Patriarchal succession, the confiscation of the vast majority of Patriarchal properties, recognition of the international Ecumenicity of the Patriarchate, and the reopening of the Theological School of Halki;

Whereas the Theological School of Halki, founded in 1844 and located outside Istanbul, Turkey, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971;

Whereas the alumni of this preeminent educational institution include numerous prominent Orthodox scholars, theologians, priests, bishops, and patriarchs, including Bartholomew I;

Whereas the Republic of Turkey has been a participating state of the Organization for Security and Cooperation in Europe (OSCE) since signing the Helsinki Final Act in 1975;

Whereas in 1989, the OSCE participating states adopted the Vienna Concluding Document, committing to respect the right of religious communities to provide ''training of religious personnel in appropriate institutions'';

Whereas the continued closure of the Ecumenical Patriarchate's Theological School of Halki has been an ongoing issue of concern for the American people and the United States Congress and has been repeatedly raised by members of the Commission on Security and Cooperation in Europe and by United States delegations to the OSCE's annual Human Dimension Implementation Meeting;

Whereas in his address to the Grand National Assembly of Turkey on April 6, 2009, President Barack Obama said, ''Freedom of religion and expression lead to a strong and vibrant civil society that only strengthens the state, which is why steps like reopening Halki Seminary will send such an important signal inside Turkey and beyond.'';

Whereas in a welcomed development, the Prime Minister of Turkey, Recep Tayyip Erdoğan, met with the Ecumenical Patriarch on August 15, 2009, and, in an address to a wider gathering of minority religious leaders that day, concluded by stating, ''We should not be of those who gather, talk, and disperse. A result should come out of this.'';

Whereas during his visit to the United States in November 2009, Ecumenical Patriarch Bartholomew I raised the issue of the continued closure of the Theological School of Halki with President Obama, congressional leaders, and others; and

Whereas Prime Minister Erdoğan is scheduled to make an official visit to Washington, D.C., in early December 2009: Now, therefore, be it

Resolved, That the Senate—

(1) welcomes the historic meeting between Prime Minister Recep Tayyip Erdoğan and Ecumenical Patriarch Bartholomew I;

(2) urges the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay; and

(3) urges the Government of Turkey to address other longstanding concerns relating to the Ecumenical Patriarchate.

Mr. CARDIN. Mr. President, I was pleased to meet with the Ecumenical Patriarch, Bartholomew I, again last week during his visit to Washington. Together with the congressional leadership, we heard his impassioned call for support for the reopening of the Theological School of Halki, an institution that has come to symbolize many of the difficulties faced by the Patriarch, the remnant of the Greek community in Turkey and other religious and ethnic minorities in that country.

I had the pleasure to meet Bartholomew I during an official visit to modern-day Istanbul in 1998. He impressed me as a man of good will, anchored in his deep personal faith, seeking to promote understanding, justice and respect for the human rights and dignity of each individual, the very qualities that prompted the Congress a year earlier to award him the Congressional Gold Medal. Indeed, his leadership extends well beyond the borders of Turkey to the Orthodox community around the world.

The Ecumenical Patriarch repeatedly returned to the issue of the Halki Seminary in various meetings during his U.S. visit, including at this oval office meeting with President Obama. Earlier this year, several of my colleagues from the Commission on Security and Cooperation in Europe, which I chair, joined me in a letter to the President underscoring our longstanding concern over the continued closure of this unique institution.

Founded in 1844, the Theological School of Halki, located outside modern-day Istanbul, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971. Counted among alumni of this preeminent educational institution are numerous prominent Orthodox scholars, theologians, priests, and bishops as well as patriarchs, including Bartholomew I. Many of these scholars and theologians have served as faculty at other institutions serving Orthodox communities around the world.

While over the years there have been occasional indications by the Turkish authorities of pending action to reopen the seminary, to date all have failed to materialize. In a potentially promising development, Turkey's Prime Minister, Recep Tayyip Erdogan, met with the Ecumenical Patriarch in August. In an address to a wider gathering of minority religious leaders that day, Erdogan concluded by stating, ''We should not be of those who gather, talk and disperse. A result should come out of this.''

I urge Prime Minister Erdoğan to follow through on the sentiment of those remarks by actions that will facilitate the reopening of the Halki Seminary without condition or further delay. As Chairman of the Helsinki Commission,

I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey's obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide ''training of religious personnel in appropriate institutions.''

At a time when Turkey is seeking to chart a new course, the resolution of this longstanding issue would not only be a demonstration of Ankara's good will, but, as President Obama mentioned in his address to the Turkish Grand National Assembly in April, will send such an important signal inside Turkey and beyond. I remain hopeful and encourage Prime Minister Erdoğan to act decisively and without condition on this matter before his upcoming visit to Washington in early December.

To underscore the importance attached to the reopening of the Theological School of Halki and our solidarity with the Ecumenical Patriarch, I am pleased to introduce a resolution on this issue together with Mr. BROWNBACK, Mr. REID, * * *

SENATE RESOLUTION 357—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING

Mr. INOUYE (for himself and Mr. REID) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 357

Whereas in 2009, the people of the world suffered many calamitous events, including devastation from tsunamis, terror attacks, wars, famines, genocides, hurricanes, earthquakes, political and religious conflicts, diseases, poverty, and rioting, all necessitating global cooperation, compassion, and unity previously unprecedented among diverse cultures, faiths, and economic classes;

Whereas grave global challenges in 2010 may require cooperation and innovative problem-solving among citizens and nations on an even greater scale;

Whereas on December 15, 2000, Congress adopted Senate Concurrent Resolution 138, expressing the sense of Congress that the President of the United States should issue a proclamation each year calling upon the people of the United States and interested organizations to observe an international day of peace and sharing at the beginning of each year;

Whereas in 2001, the United Nations General Assembly adopted Resolution 56/2, which invited ''Member States, intergovernmental and non-governmental organizations and all the peoples of the world to celebrate One Day in Peace, 1 January 2002, and every year thereafter'';

Whereas many foreign heads of State have recognized the importance of establishing Global Family Day, a special day of international unity, peace, and sharing, on the first day of each year; and

Whereas family is the basic structure of humanity, thus, we must all look to the stability and love within our individual families to create stability in the global community: Now, therefore, be it

Resolved, That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

Mr. INOUYE. Mr. President, today, I am submitting a Senate resolution to observe Global Family Day, One Day of Peace and Sharing, and am pleased to be joined in this endeavor by Senator REID.

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become even more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can promote peaceful, diplomatic options instead of war.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Protection and Affordable Care Act''.

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

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

"Subpart II—Improving Coverage

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

''(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

''(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

''(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.

"SEC. 2712. PROHIBITION ON RESCISSIONS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(b) INTERVAL.—

''(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

''(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

''(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

''(b) REGULATIONS.—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

''(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the

definition of 'dependent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

"SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

''(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the 'NAIC'), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

''(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

''(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

''(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

''(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

''(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

''(B) a description of the coverage, including cost sharing for—

''(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

''(ii) other benefits, as identified by the Secretary;

''(C) the exceptions, reductions, and limitations on coverage;

''(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

''(E) the renewability and continuation of coverage provisions;

''(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

''(G) a statement of whether the plan or coverage—

''(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

''(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

''(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

''(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

''(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

''(d) REQUIREMENT TO PROVIDE.—

''(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

''(A) an applicant at the time of application;

''(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

''(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

''(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

''(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

''(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

''(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

''(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

''(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

''(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

''(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

''(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

''(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

''(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

"SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

"SEC. 2717. ENSURING THE QUALITY OF CARE.

''(a) QUALITY REPORTING.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

''(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

''(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

''(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

''(D) implement wellness and health promotion activities.

''(2) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

''(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to

an enrollee under the plan or coverage during each open enrollment period.

''(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website

''(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

''(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

''(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

''(1) Smoking cessation.

''(2) Weight management.

''(3) Stress management.

''(4) Physical fitness.

''(5) Nutrition.

''(6) Heart disease prevention.

''(7) Healthy lifestyle support.

''(8) Diabetes prevention.

''(c) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

''(d) STUDY AND REPORT.—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

''(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

''(A) with respect to a health insurance issuer offering coverage in the group market, 20 percent, or such lower percentage as a State may by regulation determine; or

''(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) TERMINATION.—The provisions of this subsection shall have no force or effect after December 31, 2013.

''(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

''(d) DEFINITIONS.—The Secretary, in consultation with the National Association of Insurance Commissions, shall establish uniform definitions for the activities reported under subsection (a).

''SEC. 2719. APPEALS PROCESS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

''(1) have in effect an internal claims appeal process;

''(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes;

''(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and

''(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.''.

SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

''SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.

''(a) IN GENERAL.—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

''(1) offices of health insurance consumer assistance; or

''(2) health insurance ombudsman programs.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

''(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

''(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—

''(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

''(2) collect, track, and quantify problems and inquiries encountered by consumers;

''(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

''(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

''(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

''(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

''(e) FUNDING.—

''(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

''(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.''.

SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

''SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

''(a) INITIAL PREMIUM REVIEW PROCESS.—

''(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

''(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and

justifications for all health insurance issuers.

''(b) CONTINUING PREMIUM REVIEW PROCESS.—

''(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

''(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

''(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

''(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

''(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

''(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

''(c) GRANTS IN SUPPORT OF PROCESS.—

''(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

''(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

''(B) in providing information and recommendations to the Secretary under subsection (b)(1).

''(2) FUNDING.—

''(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

''(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

''(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

''(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

''(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.''.

SEC. 1004. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—

(1) IN GENERAL.—Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.—A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

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

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

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

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

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

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

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

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

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) OVERSIGHT.—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) FUNDING; TERMINATION OF AUTHORITY.—

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

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) TERMINATION OF AUTHORITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) TRANSITION TO EXCHANGE.—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIREES.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall 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 (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) REFERENCE.—In this section:

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

(B) EMPLOYMENT-BASED PLAN.—The term ''employment-based plan'' means a group health benefits plan that—

(i) is—

(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

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

(ii) provides health benefits to early retirees.

(C) EARLY RETIREES.—The term ''early retirees'' means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) PARTICIPATION.—

(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—A participating employment-based plan is an employment-based plan that—

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) EMPLOYMENT-BASED HEALTH BENEFITS.—An employment-based plan meets the requirements of this paragraph if the plan—

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified by the Secretary.

(c) PAYMENTS.—

(1) SUBMISSION OF CLAIMS.—

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

(B) BASIS FOR CLAIMS.—Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed $15,000, subject to the limits contained in paragraph (3).

(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

(4) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) APPEALS.—The Secretary shall establish—

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

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

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

(e) FUNDING.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.

(f) LIMITATION.—The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS.—

(1) IMMEDIATE ESTABLISHMENT.—Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.

(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or

(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);

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

(C) Coverage under title XXI of the Social Security Act.

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

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

(b) ENHANCING COMPARATIVE PURCHASING OPTIONS.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) USE OF FORMAT.—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(c) AUTHORITY TO CONTRACT.—The Secretary may carry out this section through contracts entered into with qualified entities.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—

(1) by inserting ''uniform'' before ''standards''; and

(2) by inserting ''and to reduce the clerical burden on patients, health care providers, and health plans'' before the period at the end.

(b) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.'';

(B) in subsection (a), by adding at the end the following new paragraph:

''(4) REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

''(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—

''(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

''(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

''(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

''(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

''(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.''; and

(C) by adding at the end the following new subsections:

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

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

''(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(E) The entity allows for public review and updates of the operating rules.

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

''(B) review the operating rules developed and recommended by such nonprofit entity;

''(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

''(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

''(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall—

''(I) allow for automated reconciliation of the electronic payment with the remittance advice; and

''(II) be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.

''(iii) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.

''(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIMS ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

''(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

''(3) SERVICE CONTRACTS.—A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

''(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—

''(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

''(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

''(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—

''(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

''(2) EVALUATIONS AND REPORTS.—

''(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

''(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

''(3) INTERIM FINAL RULEMAKING.—

''(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

''(B) PUBLIC COMMENT.—

''(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

''(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

''(4) REVIEW COMMITTEE.—

''(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

''(i) the National Committee on Vital and Health Statistics; or

''(ii) any appropriate committee as determined by the Secretary.

''(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

''(5) OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

''(j) PENALTIES.—

''(1) PENALTY FEE.—

''(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

''(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

''(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

''(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

''(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

''(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

''(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

''(i) an amount equal to $20 per covered life under such plan; or

''(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

''(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

''(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

''(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

''(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

''(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

''(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

''(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

''(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

''(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.''.

(c) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

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

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

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

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

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

SEC. 1105. EFFECTIVE DATE.

This subtitle shall 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

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

"Subpart I—General Reform";

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.''; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking ''health insurance issuer offering health insurance coverage in connection with a group health plan'' each place that such appears and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(II) in paragraph (2)(A)—

(aa) by inserting ''or individual'' after ''employer''; and

(bb) by inserting ''or individual health coverage, as the case may be'' before the semicolon; and

(iii) in subsection (e)—

(I) by striking ''(a)(1)(F)'' and inserting ''(a)(6)'';

(II) by striking ''2701'' and inserting ''2704''; and

(III) by striking ''2721(a)'' and inserting ''2735(a)''; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

"SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

''(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

''(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

''(A) such rate shall vary with respect to the particular plan or coverage involved only by—

''(i) whether such plan or coverage covers an individual or family;

''(ii) rating area, as established in accordance with paragraph (2);

''(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

''(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

''(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

''(2) RATING AREA.—

''(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

''(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

''(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

''(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

''(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

''(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

''(b) ENROLLMENT.—

''(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

''(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

''(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

"SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

''(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

"SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(1) Health status.

''(2) Medical condition (including both physical and mental illnesses).

''(3) Claims experience.

''(4) Receipt of health care.

''(5) Medical history.

''(6) Genetic information.

''(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(8) Disability.

''(9) Any other health status-related factor determined appropriate by the Secretary.

''(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

''(1) GENERAL PROVISIONS.—

''(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

''(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

''(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

''(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

''(A) A program that reimburses all or part of the cost for memberships in a fitness center.

''(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

''(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

''(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

''(E) A program that provides a reward to individuals for attending a periodic health education seminar.

''(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

''(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such

as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

''(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

''(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

''(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

''(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

''(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

''(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

''(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

''(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

''(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

''(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

''(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

''(3) REQUIREMENTS.—

''(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

''(i) will not result in any decrease in coverage; and

''(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

''(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

''(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

''(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

''(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

''(I) do not create undue burdens for individuals insured in the individual market;

''(II) do not lead to cost shifting; and

''(III) are not a subterfuge for discrimination;

''(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note); and

''(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

''(m) REPORT.—

''(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

''(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

''(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

''(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

''(D) the effectiveness of different types of rewards.

''(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

''(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

''SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

''(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

''(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

''SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

''(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

''(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

''(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

''(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

''SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.''.

PART II—OTHER PROVISIONS

SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.

(a) NO CHANGES TO EXISTING COVERAGE.—

(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term ''grandfathered health plan'' means any group health plan or health insurance coverage to which this section applies.

SEC. 1252. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

SEC. 1253. EFFECTIVE DATES.

This subtitle (and the amendments made by 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

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) QUALIFIED HEALTH PLAN.—In this title:

(1) IN GENERAL.—The term ''qualified health plan'' means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term ''health plan'' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term ''essential health benefits package'' means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(C) ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term ''cost-sharing'' includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

SEC. 1303. SPECIAL RULES.

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph

(B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) ABORTION SERVICES.—

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

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

(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) EXCEPTIONS.—Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance option. Services described in subparagraph (B)(ii) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.—

(i) IN GENERAL.—The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title—

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) SPECIAL RULES.—For purposes of clause (i)—

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

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

(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of thePatient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) SEGREGATION OF FUNDS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

(C) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

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

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

(3) PROVIDER CONSCIENCE PROTECTIONS.—No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

(b) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

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

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

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

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

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

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

(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ''EMTALA'').

SEC. 1304. RELATED DEFINITIONS.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term ''group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) INDIVIDUAL MARKET.—The term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms ''large group market'' and ''small group market'' mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) EMPLOYERS.—In this title:

(1) LARGE EMPLOYER.—The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ''51 employees'' for ''101 employees'' in paragraph (1) and by substituting ''50 employees'' for ''100 employees'' in paragraph (2).

(4) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.—If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) SECRETARY.—In this title, the term ''Secretary'' means the Secretary of Health and Human Services.

(d) STATE.—In this title, the term ''State'' means each of the 50 States and the District of Columbia.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT.—

(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ''Exchange'') for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) RESPONSIBILITIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) INTERNET PORTALS.—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(5) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(d) REQUIREMENTS.—

(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) OFFERING OF COVERAGE.—

(A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) LIMITATION.—

(i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.

(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—

(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue

Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).

(4) FUNCTIONS.—An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS.—

(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) PROHIBITING WASTEFUL USE OF FUNDS.—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS.—An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) CERTIFICATION.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY.—In this paragraph, the term ''eligible entity'' means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) the implementation of wellness and health promotion activities.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) QUALITY IMPROVEMENT.—

(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) NAVIGATORS.—

(1) IN GENERAL.—An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) ELIGIBILITY.—

(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) FUNDING.—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) CONFLICT.—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) SMALL GROUP MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) MERGER OF MARKETS.—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) EMPOWERING CONSUMER CHOICE.—

(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) VOLUNTARY NATURE OF AN EXCHANGE.—

(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.—In this section:

(I) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

(II) CONGRESSIONAL STAFF.—The term ''congressional staff'' means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) QUALIFIED INDIVIDUALS.—In this title:

(A) IN GENERAL.—The term ''qualified individual'' means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER.—In this title:

(A) IN GENERAL.—The term ''qualified employer'' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—

(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term ''qualified employer'' shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.

(4) PATTERN OF ABUSE.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) APPLICATION OF THE FALSE CLAIMS ACT.—

(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; and

(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—

(1) IN GENERAL.—If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which 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, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) PURPOSE.—It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in

which the issuers are licensed to offer such plans.

(b) LOANS AND GRANTS UNDER THE CO-OP PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—

(A) IN GENERAL.—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) STATES WITHOUT ISSUERS IN PROGRAM.—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) AGREEMENT.—

(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) ADVISORY BOARD.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) RULES RELATING TO APPOINTMENTS.—

(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) PAY AND REIMBURSEMENT.—

(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term ''qualified nonprofit health insurance issuer'' means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) CERTAIN ORGANIZATIONS PROHIBITED.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) GOVERNANCE REQUIREMENTS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

(A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) PROFITS INURE TO BENEFIT OF MEMBERS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) COMPLIANCE WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).

(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(d) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—

(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term ''antitrust laws'' has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) LIMITATIONS ON SECRETARY.—

(1) IN GENERAL.—The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(h) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

''(29) CO-OP HEALTH INSURANCE ISSUERS.—

''(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

''(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

''(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

''(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

''(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

''(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''.

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

''(m) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

''(2) The amount of reserves on hand.''.

(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking ''paragraph (3) or (4)'' and inserting ''paragraph (3), (4), or (29)''.

(i) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.

(a) VOLUNTARY NATURE.—

(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.

(3) STATE OPT OUT.—

(A) IN GENERAL.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term ''community health insurance option'' means health insurance coverage that—

(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

(B) provides high value for the premium charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) ESSENTIAL HEALTH BENEFITS.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) PREMIUMS.—

(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.

(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.

(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

(7) SOLVENCY AND CONSUMER PROTECTION.—

(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.

(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option.

(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—

(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the ''NAIC''), may promulgate regulations to establish additional requirements for a community health insurance option.

(B) APPLICABILITY.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.

(c) START-UP FUND.—

(1) ESTABLISHMENT OF FUND.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ''Health Benefit Plan Start-Up Fund'' (referred to in this section as the ''Start-Up Fund''), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.

(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—

(i) pay the start-up costs associated with the initial operations of a community health insurance option; and

(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.

(2) USE OF START-UP FUND.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).

(3) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(4) REPAYMENT.—

(A) IN GENERAL.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—

(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

(ii) permanently ineligible to offer a qualified health plan.

(d) STATE ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—

(1) AUTHORITY.—

(A) IN GENERAL.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—

(i) shall meet the criteria established under paragraph (2); and

(ii) shall receive an administrative fee under paragraph (7).

(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

(D) REFERENCE.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a ''contracting administrator''.

(2) QUALIFIED ENTITY.—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—

(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;

(B) be a nonprofit entity for purposes of offering such option;

(C) meet the solvency standards applicable under subsection (b)(7);

(D) be eligible to offer health insurance or health benefits coverage;

(E) meet quality standards specified by the Secretary;

(F) have in place effective procedures to control fraud, abuse, and waste; and

(G) meet such other requirements as the Secretary may impose.

Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

(3) TERM.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.

(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

(7) FEE FOR ADMINISTRATION.—

(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) NON-RENEWAL.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

(8) LIMITATION.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).

(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—

(1) IN GENERAL.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) RESULT.—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

(3) SUBMISSION OF PLAN AND PROCEDURE.—

(A) IN GENERAL.—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of

the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(B) PROCEDURE.—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.

(g) MARKETING PARITY.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

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

SEC. 1324. LEVEL PLAYING FIELD.

(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;
(2) rating;
(3) preexisting conditions;
(4) non-discrimination;
(5) quality improvement and reporting;
(6) fraud and abuse;
(7) solvency and financial requirements;
(8) market conduct;
(9) prompt payment;
(10) appeals and grievances;
(11) privacy and confidentiality;
(12) licensure; and
(13) benefit plan material or information.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) STANDARD HEALTH PLAN.—In this section, the term ''standard heath plan'' means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) CONTRACTING PROCESS.—

(1) IN GENERAL.—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) SPECIFIC ITEMS TO BE CONSIDERED.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) INNOVATION.—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) MANAGED CARE.—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) PERFORMANCE MEASURES.—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) ENHANCED AVAILABILITY.—

(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) TRANSFER OF FUNDS TO STATES.—

(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.

(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special

focus on enrollees with income below 200 percent of poverty.

(iii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) ELIGIBLE INDIVIDUAL.—

(1) IN GENERAL.—In this section, the term ''eligible individual'' means, with respect to any State, an individual—

(A) who a resident of the State who is not eligible to enroll in the State's medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall

notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) HEALTH CARE CHOICE COMPACTS.—

(1) IN GENERAL.—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) STATE AUTHORITY.—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

(3) APPROVAL OF COMPACTS.—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

(4) EFFECTIVE DATE.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) AUTHORITY FOR NATIONWIDE PLANS.—

(1) IN GENERAL.—Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a ''nationwide qualified health plan'')—

(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and

(B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.

(2) STATE OPT-OUT.—A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

(3) PLAN REQUIREMENTS.—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—

(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);

(B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver and gold levels of the plan in each Exchange in the State for the market in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer offers the nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such States in the second year, 70 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act; and

(G) the issuer clearly notifies consumers that the policy may not contain some benefits otherwise mandated for plans in the State in which the purchaser resides and provides a detailed statement of the benefits offered and the benefit differences in that State, in accordance with rules promulgated by the Secretary.

(4) FORM REVIEW FOR NATIONWIDE PLANS.—Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.

(5) APPLICABLE RULES.—The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.

(6) COVERAGE.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.

(7) STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.—For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A law that mandates health insurance coverage or reimbursement for services provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) IN GENERAL.—Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) MODEL REGULATION.—

(1) IN GENERAL.—In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the ''NAIC''), shall include provisions that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS.—The Secretary shall include the following in the provisions under paragraph (1):

(A) DETERMINATION OF HIGH-RISK INDIVIDUALS.—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) PAYMENT AMOUNT.—The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—

(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) SPECIFIC REQUIREMENTS.—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) EXPENDITURE OF FUNDS.—The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term ''applicable reinsurance entity'' means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) DEFINITIONS.—In this section:

(1) ALLOWABLE COSTS.—

(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

SEC. 1343. RISK ADJUSTMENT.

(a) IN GENERAL.—

(1) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) CRITERIA AND METHODS.—The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.

(c) SCOPE.—A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that 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

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

''SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

''(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

''(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

''(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

''(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

''(B) the excess (if any) of—

''(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

''(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

''(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

''(A) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—

''(I) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

''(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

''(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer's household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer's applicable percentage shall be 2 percent.

''(iii) INDEXING.—In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

''(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

''(ii) provides—

''(I) self-only coverage in the case of an applicable taxpayer—

''(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

''(bb) who is not described in item (aa) but who purchases only self-only coverage, and

''(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

''(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

''(D) ADDITIONAL BENEFITS.—If—

''(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

''(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

''(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

''(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

''(1) APPLICABLE TAXPAYER.—

''(A) IN GENERAL.—The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

''(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

''(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

''(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

''(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

''(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(2) COVERAGE MONTH.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

''(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

''(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

''(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

''(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

''(ii) MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).

''(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

''(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

''(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

''(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.8 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

''(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

''(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

''(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

''(3) DEFINITIONS AND OTHER RULES.—

''(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

''(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

''(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

''(2) HOUSEHOLD INCOME.—

''(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals who—

''(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

''(II) were required to file a return of tax imposed by section 1 for the taxable year.

''(B) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

''(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

''(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

''(iii) determined without regard to sections 911, 931, and 933.

''(3) POVERTY LINE.—

''(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

''(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

''(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

''(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

''(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

''(i) A method under which—

''(I) the taxpayer's family size is determined by not taking such individuals into account, and

''(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

''(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

''(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

''(ii) A comparable method reaching the same result as the method under clause (i).

''(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

''(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

''(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

''(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

''(2) EXCESS ADVANCE PAYMENTS.—

''(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

''(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

''(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

''(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

''(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

''(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.''.

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.''.

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term ''appropriate committees of Congress'' means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Refundable credit for coverage under a qualified health plan.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) ELIGIBLE INSURED.—In this section, the term ''eligible insured'' means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) METHODS FOR REDUCING COST-SHARING.—

(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) DEFINITIONS AND SPECIAL RULES.—In this section:

(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING , AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the

plan (in this subsection referred to as an ''enrollee''); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) APPEALS AND REDETERMINATIONS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—

(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provides correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms ''negligence'' and ''disregard'' shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) ADVANCE DETERMINATIONS.—

(1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ''applicable State health subsidy program'' means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—

(1) TAXPAYER RETURN INFORMATION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

''(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

''(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

''(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and

''(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

''(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

''(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

''(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

''(ii) determining eligibility for participation in the State programs described in subparagraph (A).''.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

''(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.''.

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A)'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20)'' both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

''SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

''(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

''(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

''(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or

''(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

''(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

''(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

''(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

''(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—

''(A) which has no more than 25 full-time equivalent employees for the taxable year,

''(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

''(C) which has in effect an arrangement described in paragraph (4).

''(2) FULL-TIME EQUIVALENT EMPLOYEES.—

''(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—

''(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

''(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

''(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

''(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(3) AVERAGE ANNUAL WAGES.—

''(A) IN GENERAL.—The average annual wages of an eligible small employer for any

taxable year is the amount determined by dividing—

''(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

''(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

''(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.

''(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

''(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

''(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

''(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

''(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE.—

''(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

''(i) an employee within the meaning of section 401(c)(1),

''(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

''(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

''(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

''(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

''(3) NONELECTIVE CONTRIBUTION.—The term 'nonelective contribution' means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

''(4) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

''(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

''(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

''(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

''(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of—

''(A) the amount of the credit determined under this section with respect to such employer, or

''(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

''(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term 'tax-exempt eligible small employer' means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

''(3) PAYROLL TAXES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'payroll taxes' means—

''(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

''(ii) amounts required to be withheld from such employees under section 3101(b), and

''(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

''(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

''(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

''(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

''(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

''(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '50 percent (35 percent in the case of a tax-exempt eligible small employer)',

''(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

''(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

''(3) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

''(h) INSURANCE DEFINITIONS.—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

''(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'', and by inserting after paragraph (35) the following:

''(36) the small employer health insurance credit determined under section 45R.''.

(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by redesignating clauses (vi), (vii), and (viii) as clauses (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

''(vi) the credit determined under section 45R,''.

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:

''(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums.''.

(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding at the end the following new paragraph:

''(14) the small employer health insurance credit determined under section 45R(a).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 45R. Employee health insurance expenses of small employers.''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the ''requirement'') is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

''CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

''Sec. 5000A. Requirement to maintain minimum essential coverage.

''SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

''(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

''(b) SHARED RESPONSIBILITY PAYMENT.—

''(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

''(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

''(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

''(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

''(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

''(c) AMOUNT OF PENALTY.—

''(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to ½ of the applicable dollar amount for the calendar year.

''(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

''(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

''(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

''(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

''(i) $750, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

''(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals who—

''(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

''(II) were required to file a return of tax imposed by section 1 for the taxable year.

''(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

''(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

''(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

''(iii) determined without regard to sections 911, 931, and 933.

''(D) POVERTY LINE.—

''(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

''(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

''(2) RELIGIOUS EXEMPTIONS.—

''(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

''(B) HEALTH CARE SHARING MINISTRY.—

''(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

''(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

''(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

''(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

''(III) members of which retain membership even after they develop a medical condition,

''(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

''(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

''(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

''(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

''(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

''(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

''(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

''(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

''(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

''(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

''(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

''(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

''(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

''(4) MONTHS DURING SHORT COVERAGE GAPS.—

''(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

''(B) SPECIAL RULES.—For purposes of applying this paragraph—

''(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

''(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

''(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

''(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

''(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

''(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

''(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

''(i) the Medicare program under part A of title XVIII of the Social Security Act,

''(ii) the Medicaid program under title XIX of the Social Security Act,

''(iii) the CHIP program under title XXI of the Social Security Act,

''(iv) the TRICARE for Life program,

''(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

''(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

''(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

''(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

''(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

''(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

''(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

''(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

''(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

''(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

''(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

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

''(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

''(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

''(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

''(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

''(g) ADMINISTRATION AND PROCEDURE.—

''(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

''(2) SPECIAL RULES.—Notwithstanding any other provision of law—

''(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

''(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

''(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

''(ii) levy on any such property with respect to such failure.''.

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

''CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

"Subpart D—Information Regarding Health Insurance Coverage

''Sec. 6055. Reporting of health insurance coverage.

"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

''(b) FORM AND MANNER OF RETURN.—

''(1) IN GENERAL.—A return is described in this subsection if such return—

''(A) is in such form as the Secretary may prescribe, and

''(B) contains—

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

''(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

''(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

''(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

''(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

''(iv) such other information as the Secretary may require.

''(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

''(A) the name, address, and employer identification number of the employer maintaining the plan,

''(B) the portion of the premium (if any) required to be paid by the employer, and

''(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(B) the information required to be shown on the return with respect to such individual.

''(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

''(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by inserting after clause (xxiii) the following new clause:

''(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'' and by inserting after subparagraph (FF) the following new subparagraph:

''(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).''.

(c) NOTIFICATION OF NONENROLLMENT.—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) CONFORMING AMENDMENT.—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:

''SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after 2013.

PART II—EMPLOYER RESPONSIBILITIES

SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

"SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

''In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.''.

SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

"SEC. 18B. NOTICE TO EMPLOYEES.

''(a) IN GENERAL.—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—

''(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

''(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

''(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

''(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.''.

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

''(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—

''(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

''(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

''(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.—

''(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

''(2) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

''(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, $400, and

''(B) in the case of an extended waiting period which exceeds 60 days, $600.

''(3) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the

Public Health Service Act) which exceeds 30 days.

''(c) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

''(1) IN GENERAL.—If—

''(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

''(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

''(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1/12 of $750.

''(2) APPLICABLE LARGE EMPLOYER.—

''(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

''(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

''(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

''(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

''(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

''(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

''(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term 'applicable premium tax credit and cost-sharing reduction' means—

''(A) any premium tax credit allowed under section 36B,

''(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

''(C) any advance payment of such credit or reduction under section 1412 of such Act.

''(4) FULL-TIME EMPLOYEE.—

''(A) IN GENERAL.—The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

''(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(5) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—

''(i) such dollar amount, and

''(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

''(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

''(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

''(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

''(e) ADMINISTRATION AND PROCEDURE.—

''(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

''(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

''(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980H. Shared responsibility for employers regarding health coverage.''.

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

''SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

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

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

''(2) contains—

''(A) the name, date, and employer identification number of the employer,

''(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

''(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

''(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,

''(ii) the months during the calendar year for which coverage under the plan was available,

''(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

''(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,

''(D) the number of full-time employees for each month during the calendar year,

''(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

''(F) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—

''(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(B) the information required to be shown on the return with respect to such individual.

''(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

''(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

''(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

''(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

''(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking ''or'' at the end of clause (xxiii), by striking ''and'' at the end of clause (xxiv) and inserting ''or'', and by inserting after clause (xxiv) the following new clause:

''(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking ''or'' at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting '', or'' and by inserting after subparagraph (GG) the following new subparagraph:

''(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).''.

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

''Sec. 6056. Large employers required to report on health insurance coverage.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

''(A) IN GENERAL.—The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

''(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.''.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking ''For purposes of this section, the term'' and inserting ''For purposes of this section—

''(1) IN GENERAL.—The term'', and

(2) by striking ''Such term shall not include'' and inserting the following:

''(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G—Miscellaneous Provisions

SEC. 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) shall apply with respect to this title.

SEC. 1552. TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

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

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

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

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

SEC. 1554. ACCESS TO THERAPIES.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.

(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking '', except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.

SEC. 1557. NONDISCRIMINATION.

(a) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) REGULATIONS.—The Secretary may promulgate regulations to implement this section.

SEC. 1558. PROTECTIONS FOR EMPLOYEES.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18B (as added by section 1512) the following:

''SEC. 18C. PROTECTIONS FOR EMPLOYEES.

''(a) PROHIBITION.—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—

''(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

''(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

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

''(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

''(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

''(b) COMPLAINT PROCEDURE.—

''(1) IN GENERAL.—An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

''(2) NO LIMITATION ON RIGHTS.—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.''.

SEC. 1559. OVERSIGHT.

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

SEC. 1560. RULES OF CONSTRUCTION.

(a) NO EFFECT ON ANTITRUST LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

(b) RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

(c) STUDENT HEALTH INSURANCE PLANS.—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) NO EFFECT ON EXISTING REQUIREMENTS.—Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

''Subtitle C—Other Provisions

''SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

''(a) IN GENERAL.—

''(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

''(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

''(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

''(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

''(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

''(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

''(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

''(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

''(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

''(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

''(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

''(1) shall notify States of such standards or protocols; and

''(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

''(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

''(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as 'appropriate HIT technology').

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

''(A) be a State, political subdivision of a State, or a local governmental entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing—

''(i) a plan to adopt and implement appropriate enrollment technology that includes—

''(I) proposed reduction in maintenance costs of technology systems;

''(II) elimination or updating of legacy systems; and

''(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

''(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

''(iii) such other information as the Secretary may require.

''(3) SHARING.—

''(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

''(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.''.

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21), as so redesignated by section 1001(4), is amended—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking ''1 through 3'' and inserting ''1 and 2''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''subparagraph (D)'' and inserting ''subparagraph (D) or (E)'';

(ii) by striking ''1 through 3'' and inserting ''1 and 2''; and

(iii) by adding at the end the following:

''(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.'';

(3) in subsection (c), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(4) in subsection (d)—

(A) in paragraph (1), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group'';

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(ii) in subparagraph (C), by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer''; and

(C) in paragraph (3), by striking ''any group'' and inserting ''any individual coverage or any group''.

(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg-91(d)) is amended by adding at the end the following:

''(20) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

''(21) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in section 2704 (42 U.S.C. 300gg), as so redesignated by section 1201(2)—

(A) in subsection (c)—

(i) in paragraph (2), by striking ''group health plan'' each place that such term appears and inserting ''group or individual health plan''; and

(ii) in paragraph (3)—

(I) by striking ''group health insurance'' each place that such term appears and inserting ''group or individual health insurance''; and

(II) in subparagraph (D), by striking ''small or large'' and inserting ''individual or group'';

(B) in subsection (d), by striking ''group health insurance'' each place that such term appears and inserting ''group or individual health insurance''; and

(C) in subsection (e)(1)(A), by striking ''group health insurance'' and inserting ''group or individual health insurance'';

(2) by striking the second heading for subpart 2 of part A (relating to other requirements);

(3) in section 2725 (42 U.S.C. 300gg-4), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b)—

(i) by striking ''health insurance issuer offering group health insurance coverage in connection with a group health plan'' in the matter preceding paragraph (1) and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (1), by striking ''plan'' and inserting ''plan or coverage'';

(C) in subsection (c)—

(i) in paragraph (2), by striking ''group health insurance coverage offered by a health insurance issuer'' and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (3), by striking ''issuer'' and inserting ''health insurance issuer''; and

(D) in subsection (e), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(4) in section 2726 (42 U.S.C. 300gg-5), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage''; and

(C) in subsection (c)—

(i) in paragraph (1), by striking ''(and group health insurance coverage offered in connection with a group health plan)'' and inserting ''and a health insurance issuer offering group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(5) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ''health insurance issuers providing health insurance coverage in connection with group health plans'' and inserting ''and health insurance issuers offering group or individual health insurance coverage'';

(6) in section 2728 (42 U.S.C. 300gg-7), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance coverage offered in connection with such plan'' and inserting ''individual health insurance coverage'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''or a health insurance issuer that provides health insurance coverage in connection with a group health plan'' and inserting ''or a health insurance issuer that offers group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''health insurance coverage offered in connection with the plan'' and inserting ''individual health insurance coverage''; and

(iii) in paragraph (3), by striking ''health insurance coverage offered by an issuer in connection with such plan'' and inserting ''individual health insurance coverage'';

(C) in subsection (c), by striking ''health insurance issuer providing health insurance coverage in connection with a group health plan'' and inserting ''health insurance issuer that offers group or individual health insurance coverage''; and

(D) in subsection (e)(1), by striking ''health insurance coverage offered in connection with such a plan'' and inserting ''individual health insurance coverage'';

(7) by striking the heading for subpart 3;

(8) in section 2731 (42 U.S.C. 300gg-11), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (b);

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small group'' and inserting ''group and individual''; and

(II) in subparagraph (B)—

(aa) in the matter preceding clause (i), by inserting ''and individuals'' after ''employers'';

(bb) in clause (i), by inserting ''or any additional individuals'' after ''additional groups''; and

(cc) in clause (ii), by striking ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' and inserting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals''; and

(ii) in paragraph (2), by striking ''small group'' and inserting ''group or individual'';

(C) in subsection (d)—

(i) by striking ''small group'' each place that such appears and inserting ''group or individual''; and

(ii) in paragraph (1)(B)—

(I) by striking ''all employers'' and inserting ''all employers and individuals'';

(II) by striking ''those employers'' and inserting ''those individuals, employers''; and

(III) by striking ''such employees'' and inserting ''such individuals, employees'';

(D) by striking subsection (e);

(E) by striking subsection (f); and

(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));

(9) in section 2732 (42 U.S.C. 300gg-12), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (a);

(B) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking ''group health plan in the small or large group market'' and inserting ''health insurance coverage offered in the group or individual market'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''plan sponsor'';

(iii) in paragraph (2), by inserting '', or individual, as applicable,'' after ''plan sponsor''; and

(iv) by striking paragraph (3) and inserting the following:

''(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.'';

(C) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''group health insurance coverage offered in the small or large group market'' and inserting ''group or individual health insurance coverage'';

(II) in subparagraph (A), by inserting ''or individual, as applicable,'' after ''plan sponsor'';

(III) in subparagraph (B)—

(aa) by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(bb) by inserting ''or individual health insurance coverage''; and

(IV) in subparagraph (C), by inserting ''or individuals, as applicable,'' after ''those sponsors''; and

(ii) in paragraph (2)(A)—

(I) in the matter preceding clause (i), by striking ''small group market or the large group market, or both markets,'' and inserting ''individual or group market, or all markets,''; and

(II) in clause (i), by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(D) by transferring such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));

(10) in section 2733 (42 U.S.C. 300gg-13), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in the matter preceding paragraph (1), by striking ''small employer'' and inserting ''small employer or an individual'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''employer'' each place that such appears; and

(iii) in paragraph (2), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(B) in subsection (b)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(II) in subparagraph (A), by adding ''and'' at the end;

(III) by striking subparagraphs (B) and (C); and

(IV) in subparagraph (D)—

(aa) by inserting '', or individual, as applicable,'' after ''employer''; and

(bb) by redesignating such subparagraph as subparagraph (B);

(ii) in paragraph (2)—

(I) by striking ''small employers'' each place that such term appears and inserting

''employers, or individuals, as applicable,''; and

(II) by striking ''small employer'' and inserting ''employer, or individual, as applicable,''; and

(C) by redesignating such section (as amended by this paragraph) as section 2709 and transferring such section to appear after section 2708 (as added by section 1001(5));

(11) by redesignating subpart 4 as subpart 2;

(12) in section 2735 (42 U.S.C. 300gg-21), as so redesignated by section 1001(4)—

(A) by striking subsection (a);

(B) by striking ''subparts 1 through 3'' each place that such appears and inserting ''subpart 1'';

(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and

(D) by redesignating such section (as amended by this paragraph) as section 2722;

(13) in section 2736 (42 U.S.C. 300gg-22), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''small or large group markets'' and inserting ''individual or group market''; and

(ii) in paragraph (2), by inserting ''or individual health insurance coverage'' after ''group health plans'';

(B) in subsection (b)(1)(B), by inserting ''individual health insurance coverage or'' after ''respect to''; and

(C) by redesignating such section (as amended by this paragraph) as section 2723;

(14) in section 2737(a)(1) (42 U.S.C. 300gg-23), as so redesignated by section 1001(4)—

(A) by inserting ''individual or'' before ''group health insurance''; and

(B) by redesignating such section(as amended by this paragraph) as section 2724;

(15) in section 2762 (42 U.S.C. 300gg-62)—

(A) in the section heading by inserting ''and application'' before the period; and

(B) by adding at the end the following:

''(c) APPLICATION OF PART A PROVISIONS.—

''(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

''(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.''; and

(16) in section 2791(e) (42 U.S.C. 300gg-91(e))—

(A) in paragraph (2), by striking ''51'' and inserting ''101''; and

(B) in paragraph (4)—

(i) by striking ''at least 2'' each place that such appears and inserting ''at least 1''; and

(ii) by striking ''50'' and inserting ''100''.

(d) APPLICATION.—Notwithstanding any other provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to—

(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or

(2) restrict the application of the amendments made by this subtitle.

(e) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.) is amended, by adding at the end the following:

''SEC. 715. ADDITIONAL MARKET REFORMS.

''(a) GENERAL RULE.—Except as provided in subsection (b)—

''(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

''(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

''(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.''.

(f) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9815. ADDITIONAL MARKET REFORMS.

''(a) GENERAL RULE.—Except as provided in subsection (b)—

''(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

''(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

''(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.''.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

''(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);''.

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

''(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.''.

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking ''or'' at the end;

(ii) in paragraph (25), by striking the period and inserting ''; or''; and

(iii) by adding at the end the following:

''(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).''.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting ''subsection (y) and'' before ''section 1933(d)''; and

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

''(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

''(1) AMOUNT OF INCREASE.—

''(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

''(B) 2017 AND 2018.—

''(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

''(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

''(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

''For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

''(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

''(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

''(D) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

''(2) DEFINITIONS.—In this subsection:

''(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

''(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).''.

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

''(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

''(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.''.

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

''(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.''.

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking ''and (XIV)'' and inserting ''(XIV)'' and by inserting ''and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)'' before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking ''100'' and inserting ''133''.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by inserting ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting ''subclause (VIII) of section 1902(a)(10)(A)(i) or under'' after ''eligible under''.

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting ''; and''; and

(C) by inserting after paragraph (73) the following new paragraph:

''(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).''; and

(2) by adding at the end the following new subsection:

''(gg) MAINTENANCE OF EFFORT.—

''(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

''(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

''(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

''(4) DETERMINATION OF COMPLIANCE.—

''(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—A State's determination of income

in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

''(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).''.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6),'' before ''each'';

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'';

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

''(iv) Coverage of prescription drugs.

''(v) Mental health services.''; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

''(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

''(6) MENTAL HEALTH SERVICES PARITY.—

''(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).''.

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking ''and'' at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

''(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

''(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

''(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.''.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking ''or'' at the end;

(ii) in subclause (XIX), by adding ''or'' at the end; and

(iii) by adding at the end the following new subclause:

''(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);'' and

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

''(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

''(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiii);

(ii) by inserting ''or'' at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting ''or clause (ii)(XX)'' after ''clause (i)(VIII)''.

SEC. 2002. INCOME ELIGIBILITY FOR NON-ELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

''(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of

this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

''(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

''(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

''(D) EXCEPTIONS.—

''(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

''(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

''(II) Individuals who have attained age 65.

''(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

''(IV) Individuals described in subsection (a)(10)(C).

''(V) Individuals described in any clause of subsection (a)(10)(E).

''(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

''(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

''(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

''(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

''(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

''(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

''(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms 'modified gross income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

''(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

''(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

''(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting ''(e)(14),'' before ''(l)(3)''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) IN GENERAL.—Section 1906A of such Act (42 U.S.C. 1396e–1) is amended—

(1) in subsection (a)—

(A) by striking ''may elect to'' and inserting ''shall'';

(B) by striking ''under age 19''; and

(C) by inserting '', in the case of an individual under age 19,'' after ''(and'';

(2) in subsection (c), in the first sentence, by striking ''under age 19''; and

(3) in subsection (d)—

(A) in paragraph (2)—

(i) in the first sentence, by striking ''under age 19''; and

(ii) by striking the third sentence and inserting ''A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.''; and

(B) in paragraph (3), by striking ''the parent of an individual under age 19'' and inserting ''an individual (or the parent of an individual)''; and

(4) in subsection (e), by striking ''under age 19'' each place it appears.

(b) CONFORMING AMENDMENT.—The heading for section 1906A of such Act (42 U.S.C. 1396e–1) is amended by striking ''OPTION FOR CHILDREN''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking ''or'' at the end of subclause (VII);

(2) by adding ''or'' at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

''(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;''.

(b) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting '', clause (i)(IX),'' after ''clause (i)(VIII)''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting ''1902(a)(10)(A)(i)(IX),'' after ''1902(a)(10)(A)(i)(VIII),''.

(2) Section 1937(a)(2)(B)(viii) of such Act (42 U.S.C. 1396u–7(a)(2)(B)(viii)) is amended by inserting '', or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)'' before the period.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) INCREASE IN LIMIT ON PAYMENTS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (5)'';

(2) in paragraph (4), by striking ''and (3)'' and inserting ''(3), and (4)''; and

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

''(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.''.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking ''to fiscal years beginning'' and inserting ''to—

''(A) fiscal years beginning'';

(2) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a waiver on the date of enactment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.''.

(c) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''shall be 50 per centum'' and inserting ''shall be 55 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

(1) in subsection (b), in the first sentence, by striking ''subsection (y)'' and inserting ''subsections (y) and (aa)''; and

(2) by adding at the end the following new subsection:

''(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

''(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5.

''(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

''(2) In this subsection, the term 'disaster-recovery FMAP adjustment State' means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

''(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

''(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

''(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.''.

SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w–1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended—

(1) in subparagraph (A), by striking ''$100,000,000'' and inserting ''$0''; and

(2) in subparagraph (B), by striking ''$150,000,000'' and inserting ''$0''.

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

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following:

''Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).''.

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

''(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

''(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

''(ii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

''(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.''.

(2) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period '', except as required under section 1902(e)(14)''.

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting ''or any children enrolled on or after October 1, 2013'' before the period.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

(1) STATE PLAN REQUIREMENT.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' after the semicolon;

(B) in clause (iv), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).''.

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

''(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income).''.

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

''(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).''.

(f) CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as ''CHIPRA''):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.''.

(2) Section 605 of CHIPRA is amended by striking ''legal residents'' and insert ''lawfully residing in the United States''.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking '', respectively''.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking ''section 1903(a)(3)(F)'' and inserting ''section 1903(a)(3)(G)''.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking ''the child population growth factor under section 2104(m)(5)(B)'' and inserting ''a high-performing State under section 2111(b)(3)(B)''.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397jj(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking ''school or school system'' and inserting ''local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965''.

(8) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking ''is amended'' and all that follows through ''adding'' and inserting ''is amended by adding''; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) ARRA.—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking ''or (i)'' and inserting '', (i), or (j)''.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

''(a) CONDITION FOR PARTICIPATION IN MEDICAID.—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

''(b) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.—

''(1) IN GENERAL.—A State shall establish procedures for—

''(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

''(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for—

''(i) medical assistance under the State plan or under a waiver of the plan; or

''(ii) child health assistance under the State child health plan under title XXI;

''(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

''(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the 'State Medicaid agency'), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the 'State CHIP agency') and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this title, title XXI, or a qualified health plan, as appropriate;

''(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

''(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

''(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

''(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

''(4) ENROLLMENT WEBSITE REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

''(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).''.

SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking ''at the option of the State, provide'' and inserting ''provide—

''(A) at the option of the State,'';

(2) by inserting ''and'' after the semicolon; and

(3) by adding at the end the following:

''(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;''.

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)v)) is amended—

(1) by striking ''or for'' and inserting ''for''; and

(2) by inserting before the period at the end the following: '', or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital;

''(ii) where childbirth is planned to occur away from the pregnant woman's residence;

''(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

''(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

''(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term 'birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the matter preceding clause (i) by striking ''and (21)'' and inserting '', (21), and (28)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(2) by adding at the end the following new subparagraph:

''(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.''.

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting ''(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made'' after ''hospice care''.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking ''or'' at the end;

(B) in subclause (XX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

''(ii)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42

U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking ''and (XV)'' and inserting ''(XV)''; and

(B) by inserting '', and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xiv), by striking ''or'' at the end;

(ii) in clause (xv), by adding ''or'' at the end; and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(ii),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting ''1902(a)(10)(A)(ii)(XXI),'' after ''1902(a)(10)(A)(ii)(XX),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period; and

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''; and

(ii) in subparagraph (B), by striking ''or 1920B'' and inserting ''1920B, or 1920C''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting ''or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,'' after ''1920B during a presumptive eligibility period under such section,''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 2001(c), is amended by adding at the end the following:

''(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

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

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

''(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

''(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

''(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

''(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

''(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

''(iv) the furnishing of which—

''(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

''(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

''(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

''(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

''(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

''(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

''(iii) voluntary training on how to select, manage, and dismiss attendants.

''(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

''(i) room and board costs for the individual;

''(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

''(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

''(iv) medical supplies and equipment; or

''(v) home modifications.

''(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

''(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

''(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

''(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

''(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

''(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

''(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

''(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

''(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community- based attendant services and supports that—

''(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

''(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

''(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

''(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

''(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

''(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

''(A) withholding and payment of Federal and State income and payroll taxes;

''(B) the provision of unemployment and workers compensation insurance;

''(C) maintenance of general liability insurance; and

''(D) occupational health and safety.

''(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

''(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

''(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

''(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

''(ii) The number of individuals that received such services and supports during the preceding fiscal year.

''(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

''(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

''(C) REPORTS.—Not later than—

''(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

''(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

''(6) DEFINITIONS.—In this subsection:

''(A) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

''(B) CONSUMER CONTROLLED.—The term 'consumer controlled' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

''(C) DELIVERY MODELS.—

''(i) AGENCY-PROVIDER MODEL.—The term 'agency-provider model' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

''(ii) OTHER MODELS.—The term 'other models' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

''(D) HEALTH-RELATED TASKS.—The term 'health-related tasks' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

''(E) INDIVIDUAL'S REPRESENTATIVE.—The term 'individual's representative' means a parent, family member, guardian, advocate, or other authorized representative of an individual.

''(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.''.

SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

''(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

''(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

''(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

''(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

''(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

''(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

''(B) 5-YEAR TERM.—

''(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

''(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

''(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

''(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

''(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.''.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking ''or such other services requested by the State as the Secretary may approve''.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended—

(A) in subclause (XX), by striking ''or'' at the end;

(B) in subclause (XXI), by adding ''or'' at the end; and

(C) by inserting after subclause (XXI), the following new subclause:

''(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XXII),'' after ''1902(a)(10)(A)(ii)(XXI),''.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking ''or'' at the end;

(ii) in clause (xvi), by adding ''or'' at the end; and

(iii) by inserting after clause (xvi) the following new clause:

''(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,''.

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.''; and

(2) in subclause (II) of subparagraph (D)(ii), by striking ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services'' and inserting ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria''.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking ''1902(a)(1) (relating to statewideness)'' and inserting ''1902(a)(10)(B) (relating to comparability)''.

(g) EFFECTIVE DATE.—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking ''fiscal year 2011'' and inserting ''each of fiscal years 2011 through 2016''; and

(B) in paragraph (2), by striking ''2011'' and inserting ''2016''.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking ''2011'' and inserting ''2016''.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking '', for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State'' and inserting ''for a period of not less than 90 consecutive days''; and

(B) by adding at the end the following:

''Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–

5(h)(1)(A)) shall be applied as though ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)''.

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also know as the ''Pepper Commission'', released its ''Call for Action'' blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking ''and'' at the end;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

(II) by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent.''; and

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

''(iii) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

''(I) IN GENERAL.—In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

''(II) DRUG DESCRIBED.—For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

''(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

''(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.''.

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

''(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

''(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

''(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

''(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d).''.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by inserting ''and before January 1, 2010,'' after ''December 31, 1993,''; and

(B) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) after December 31, 2009, is 13 percent.''.

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting '', including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs'' before the period; and

(ii) in paragraph (2)(A), by inserting ''including such information reported by each medicaid managed care organization,'' after ''for which payment was made under the plan during the period,''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF NEW FORMULATIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

''(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

''(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

''(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

''(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.''.

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking ''1927(c)(4)'' and inserting ''1927(c)(3)''; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

''(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

''(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

''(B) Barbiturates.

''(C) Benzodiazepines.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) in paragraph (4), by striking ''(or, effective January 1, 2007, two or more)''; and

(B) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.''.

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking ''by'' and all that follows through the period and inserting ''by—

''(i) wholesalers for drugs distributed to retail community pharmacies; and

''(ii) retail community pharmacies that purchase drugs directly from the manufacturer.''; and

(B) by striking subparagraph (B) and inserting the following:

''(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

''(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

''(I) customary prompt pay discounts extended to wholesalers;

''(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

''(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

''(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

''(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.''; and

(C) in subparagraph (C), by striking ''the retail pharmacy class of trade'' and inserting ''retail community pharmacies''.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking ''the State'' and inserting ''the United States''; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting ''and'' after the semicolon;

(ii) in clause (ii), by striking ''; and'' and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALER.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

''(10) RETAIL COMMUNITY PHARMACY.—The term 'retail community pharmacy' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

''(11) WHOLESALER.—The term 'wholesaler' means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer's and distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.''.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (iii) the following:

''(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;''; and

(B) in the second sentence, by inserting ''(relating to the weighted average of the most recently reported monthly average manufacturer prices)'' after ''(D)(v)''; and

(2) in subparagraph (D)(v), by striking ''average manufacturer prices'' and inserting ''the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)''.

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting ''with respect to a retail community pharmacy,'' before ''the determination''; and

(2) in subparagraph (C)(ii), by striking ''retail pharmacies'' and inserting ''retail community pharmacies''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking ''and (3)'' and inserting '', (3), and (7)'';

(2) in paragraph (3)(A), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (7)'';

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

''(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

''(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

''(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

''(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

''(i) UNINSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

''(II) if the State is any other State, the applicable percentage is 50 percent.

''(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year—

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

''(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

''(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

''(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

''(E) MINIMUM ALLOTMENT.—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

''(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term 'uncovered individuals' means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting ''(1)'' after ''(h)'';

(2) by inserting '', or a waiver described in paragraph (2)'' after ''(e)''; and

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

''(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

''(B) In this paragraph, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (b), by adding at the end the following new sentence: ''Subsection (h)(2) shall apply to a waiver under this subsection.'';

(B) in subsection (c)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection'';

(C) in subsection (d)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''; and

(B) in subsection (f)(6), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''.

SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) IN GENERAL.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(2) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6)), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

''SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

''(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

''(b) DEADLINES.—

''(1) RECOMMENDED MEASURES.—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

''(2) DISSEMINATION.—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

''(3) STANDARDIZED REPORTING.—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

''(4) REPORTS TO CONGRESS.—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

''(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

''(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).

''(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

''(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

''(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the—

''(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

''(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

''(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

''(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section. the term ''health care-acquired condition'' means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) MEDICARE PROVISIONS.—In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

''SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

''(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

''(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of

section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

''(2) METHODOLOGY.—

''(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

''(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

''(ii) shall be established consistent with section 1902(a)(30)(A).

''(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

''(3) PLANNING GRANTS.—

''(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

''(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

''(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

''(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

''(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

''(f) MONITORING.—A State shall include in the State plan amendment—

''(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

''(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

''(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

''(h) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who—

''(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

''(ii) has at least—

''(I) 2 chronic conditions;

''(II) 1 chronic condition and is at risk of having a second chronic condition; or

''(III) 1 serious and persistent mental health condition.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

''(2) CHRONIC CONDITION.—The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

''(A) A mental health condition.

''(B) Substance use disorder.

''(C) Asthma.

''(D) Diabetes.

''(E) Heart disease.

''(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

''(3) HEALTH HOME.—The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

''(4) HEALTH HOME SERVICES.—

''(A) IN GENERAL.—The term 'health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

''(i) comprehensive care management;

''(ii) care coordination and health promotion;

''(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

''(iv) patient and family support (including authorized representatives);

''(v) referral to community and social support services, if relevant; and

''(vi) use of health information technology to link services, as feasible and appropriate.

''(5) DESIGNATED PROVIDER.—The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

''(A) has the systems and infrastructure in place to provide health home services; and

''(B) satisfies the qualification standards established by the Secretary under subsection (b).

''(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may—

''(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

''(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

''(7) HEALTH TEAM.—The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.''.

(b) EVALUATION.—

(1) INDEPENDENT EVALUATION.—

(A) IN GENERAL.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) EVALUATION REPORT.—Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) SURVEY AND INTERIM REPORT.—

(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(A) with respect to an episode of care that includes a hospitalization; and

(B) for concurrent physicians services provided during a hospitalization.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the

Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) EVALUATION AND REPORT.—

(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act, as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term ''eligible safety net hospital system or network'' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) EVALUATION.—

(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

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

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

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

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

(1) have attained age 21, but have not attained age 65;

(2) are eligible for medical assistance under such plan; and

(3) require such medical assistance to stabilize an emergency medical condition.

(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)) . This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) IN GENERAL.—An eligible State is a State that has made an application and has

been selected pursuant to paragraphs (2) and (3).

(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

(4) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

(f) EVALUATION AND REPORT TO CONGRESS.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ''Federal medical assistance percentage'' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ''medical assistance'' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) STABILIZED.—The term ''stabilized'' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

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

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting ''FOR ALL STATES'' before ''AND ANNUAL''; and

(ii) in subparagraph (A), by striking ''children's'';

(iii) in subparagraph (B), by inserting '', the Secretary, and States'' after ''Congress'';

(iv) in subparagraph (C), by striking ''March 1'' and inserting ''March 15''; and

(v) in subparagraph (D), by striking ''June 1'' and inserting ''June 15'';

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting ''the efficient provision of'' after ''expenditures for''; and

(bb) by striking ''hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees'' and inserting ''payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services''; and

(II) in clause (iii), by inserting ''(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)'' after ''beneficiaries'';

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

''(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

''(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

''(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

''(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.'';

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

''(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.'' and

(v) in subparagraph (H) (as so redesignated), by inserting ''and preventive, acute, and long-term services and supports'' after ''barriers'';

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

''(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

''(A) review national and State-specific Medicaid and CHIP data; and

''(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.'';

(E) in paragraph (4), as redesignated by subparagraph (C), by striking ''or any other problems'' and all that follows through the period and inserting '', as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.'';

(F) in paragraph (5), as so redesignated,—

(i) in the paragraph heading, by inserting ''AND REGULATIONS'' after ''REPORTS''; and

(ii) by striking ''If'' and inserting the following:

''(A) CERTAIN SECRETARIAL REPORTS.—If''; and

(iii) in the second sentence, by inserting ''and the Secretary'' after ''appropriate committees of Congress''; and

(iv) by adding at the end the following:

''(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.'';

(G) in paragraph (10), as so redesignated, by inserting '', and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations'' before the period; and

(H) by adding at the end the following:

''(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

''(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

''(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

''(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

''(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

''(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.'';

(2) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B) and inserting the following:

''(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

''(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.''.

(3) in subsection (d)(2), by inserting ''and State'' after ''Federal'';

(4) in subsection (e)(1), in the first sentence, by inserting ''and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP,'' after ''United States''; and

(5) in subsection (f)—

(A) in the subsection heading, by striking ''AUTHORIZATION OF APPROPRIATIONS'' and inserting ''FUNDING'';

(B) in paragraph (1), by inserting ''(other than for fiscal year 2010)'' before ''in the same manner''; and

(C) by adding at the end the following:

''(3) FUNDING FOR FISCAL YEAR 2010.—

''(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

''(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

''(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.''.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), is amended—

(1) in paragraph (1)(C), by striking ''March 1 of each year (beginning with 1998)'' and inserting ''March 15'';

(2) in paragraph (1)(D), by inserting '', and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible'' before the period; and

(3) by adding at the end the following:

''(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as 'MACPAC').

''(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

''(11) INTERACTION OF MEDICAID AND MEDICARE.—The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.''.

Subtitle K—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting ''AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS'' after ''AGENCIES''; and

(2) by adding at the end the following:

''(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).''.

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking ''In this section'' and inserting ''For purposes of this section, title XIX, and title XXI''.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

''SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to strengthen and improve the programs and activities carried out under this title;

''(2) to improve coordination of services for at risk communities; and

''(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

''(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

''(A) communities with concentrations of—

''(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

''(ii) poverty;

''(iii) crime;

''(iv) domestic violence;

''(v) high rates of high-school drop-outs;

''(vi) substance abuse;

''(vii) unemployment; or

''(viii) child maltreatment;

''(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

''(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

''(ii) the gaps in early childhood home visitation in the State; and

''(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

''(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

''(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

''(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

''(A) the results of the statewide needs assessment required under paragraph (1); and

''(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

''(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

''(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) 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, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

''(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

''(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

''(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

''(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

''(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

''(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

''(i) Improved maternal and newborn health.

''(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

''(iii) Improvement in school readiness and achievement.

''(iv) Reduction in crime or domestic violence.

''(v) Improvements in family economic self-sufficiency.

''(vi) Improvements in the coordination and referrals for other community resources and supports.

''(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

''(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

''(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

''(iii) TECHNICAL ASSISTANCE.—

''(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

''(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

''(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

''(C) FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

''(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

''(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

''(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

''(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes.

''(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

''(iii) Improvements in parenting skills.

''(iv) Improvements in school readiness and child academic achievement.

''(v) Reductions in crime or domestic violence.

''(vi) Improvements in family economic self-sufficiency.

''(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

''(3) CORE COMPONENTS.—The program includes the following core components:

''(A) SERVICE DELIVERY MODEL OR MODELS.—

''(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

''(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

''(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

''(bb) quasi-experimental research designs.

''(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

''(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity

shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

''(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

''(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

''(iii) The program maintains high quality supervision to establish home visitor competencies.

''(iv) The program demonstrates strong organizational capacity to implement the activities involved.

''(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

''(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

''(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

''(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

''(B) Low-income eligible families.

''(C) Eligible families who are pregnant women who have not attained age 21.

''(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

''(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

''(F) Eligible families that have users of tobacco products in the home.

''(G) Eligible families that are or have children with low student achievement.

''(H) Eligible families with children with developmental delays or disabilities.

''(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

''(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

''(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

''(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

''(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

''(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

''(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

''(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

''(7) Assurances that the entity will establish procedures to ensure that—

''(A) the participation of each eligible family in the program is voluntary; and

''(B) services are provided to an eligible family in accordance with the individual assessment for that family.

''(8) Assurances that the entity will—

''(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

''(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

''(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

''(10) Other information as required by the Secretary.

''(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

''(g) EVALUATION.—

''(1) INDEPENDENT, EXPERT ADVISORY PANEL.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

''(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

''(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

''(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

''(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

''(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

''(B) an assessment of—

''(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

''(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

''(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

''(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

''(h) OTHER PROVISIONS.—

''(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

''(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

''(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

''(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

''(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

''(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

''(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

''(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection

to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

''(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

''(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

''(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

''(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

''(B) REQUIREMENTS.—The Secretary shall ensure that—

''(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

''(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

''(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

''(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

''(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

''(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

''(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

''(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(C) Section 504(d) (relating to a limitation on administrative expenditures).

''(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to nondiscrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(j) APPROPRIATIONS.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

''(A) $100,000,000 for fiscal year 2010;

''(B) $250,000,000 for fiscal year 2011;

''(C) $350,000,000 for fiscal year 2012;

''(D) $400,000,000 for fiscal year 2013; and

''(E) $400,000,000 for fiscal year 2014.

''(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

''(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

''(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

''(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

''(k) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—

''(A) IN GENERAL.—The term 'eligible entity' means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

''(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

''(2) ELIGIBLE FAMILY.—The term 'eligible family' means—

''(A) a woman who is pregnant, and the father of the child if the father is available; or

''(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

''(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian Tribe' and 'Tribal Organization', and 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) RESEARCH ON POSTPARTUM CONDITIONS.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the ''Secretary'') is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as ''postpartum conditions''), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

(i) include public service announcements through television, radio, and other means; and

(ii) focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2951, is amended by adding at the end the following new section:

''SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

''(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants 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.

''(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

''(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

''(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

''(3) Improving the quality, availability, and organization of health care and support services (including transportation services,

attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

''(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

''(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

''(B) in the case of a grantee that is a State, hospital, or birthing facility—

''(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

''(ii) ensuring that training programs regarding such education are carried out at the health facility.

''(c) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

''(d) REQUIREMENTS.—The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report to the Secretary that describes how grant funds were used during such period.

''(e) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

''(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

''(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(C) Section 504(d) (relating to a limitation on administrative expenditures).

''(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to nondiscrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(g) DEFINITIONS.—In this section:

''(1) The term 'eligible entity'—

''(A) means a public or nonprofit private entity; and

''(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

''(2) The term 'postpartum condition' means postpartum depression or postpartum psychosis.''.

(c) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) $3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

''SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.

''(a) ALLOTMENTS TO STATES.—

''(1) AMOUNT.—

''(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

''(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

''(ii) the State youth population percentage determined under paragraph (2).

''(B) MINIMUM ALLOTMENT.—

''(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

''(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

''(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

''(i) IN GENERAL.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

''(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

''(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

''(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

''(III) A description of the State's plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

''(2) STATE YOUTH POPULATION PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

''(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

''(ii) the number of such individuals in all States.

''(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

''(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

''(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

''(B) 3-YEAR GRANTS.—

''(i) IN GENERAL.—The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

''(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

''(C) EVALUATION.—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

''(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

''(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

''(b) PURPOSE.—

''(1) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants

made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

''(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

''(A) IN GENERAL.—In this section, the term 'personal responsibility education program' means a program that is designed to educate adolescents on—

''(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

''(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

''(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

''(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

''(ii) The program is medically-accurate and complete.

''(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

''(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

''(v) The program provides age-appropriate information and activities.

''(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

''(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

''(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

''(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

''(iii) Financial literacy.

''(iv) Parent-child communication.

''(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

''(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

''(c) RESERVATIONS OF FUNDS.—

''(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

''(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

''(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

''(B) SECRETARIAL RESPONSIBILITIES.—

''(i) RESERVATION OF FUNDS.—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

''(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

''(iii) EVALUATION.—The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

''(2) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

''(B) EXCEPTIONS.—The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(iii) Section 504(d) (relating to a limitation on administrative expenditures).

''(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(v) Section 507 (relating to penalties for false statements).

''(vi) Section 508 (relating to nondiscrimination).

''(e) DEFINITIONS.—In this section:

''(1) AGE-APPROPRIATE.—The term 'age-appropriate', with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

''(2) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

''(A) published in peer-reviewed journals, where applicable; or

''(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

''(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms 'Indian tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

''(4) YOUTH.—The term 'youth' means an individual who has attained age 10 but has not attained age 20.

''(f) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking ''fiscal year 1998 and each subsequent fiscal year'' and inserting ''each of fiscal years 2010 through 2014''; and

(2) in subsection (d)—

(A) in the first sentence, by striking ''1998 through 2003'' and inserting ''2010 through 2014''; and

(B) in the second sentence, by inserting ''(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)'' before the period.

SEC. 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) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting ''includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,'' after ''employment services,''.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

''(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.''.

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking ''and'' at the end; and

(2) by adding at the end the following:

''(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on 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

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the 'Program') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

''(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

''(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term 'hospital' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

''(ii) EXCLUSIONS.—The term 'hospital' shall not include, with respect to a fiscal year, a hospital—

''(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

''(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

''(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

''(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

''(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

''(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

''(2) MEASURES.—

''(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

''(B) REQUIREMENTS.—

''(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

''(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

''(aa) Acute myocardial infarction (AMI).

''(bb) Heart failure.

''(cc) Pneumonia.

''(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

''(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

''(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

''(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of 'Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

''(C) LIMITATIONS.—

''(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

''(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

''(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

''(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

''(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

''(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

''(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

''(ii) historical performance standards;

''(iii) improvement rates; and

''(iv) the opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

''(5) HOSPITAL PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital performance score') for each hospital for each performance period.

''(B) APPLICATION.—

''(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

''(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

''(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

''(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

''(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

''(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

''(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

''(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

''(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

''(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

''(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

''(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

''(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

''(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

''(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

''(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

''(B) ADJUSTMENT TO PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

''(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

''(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term 'applicable percent' means—

''(i) with respect to fiscal year 2013, 1.0 percent;

''(ii) with respect to fiscal year 2014, 1.25 percent;

''(iii) with respect to fiscal year 2015, 1.5 percent;

''(iv) with respect to fiscal year 2016, 1.75 percent; and

''(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

''(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

''(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

''(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

''(II) any portion of such payment amount that is attributable to—

''(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

''(bb) such other payments under subsection (d) determined appropriate by the Secretary.

''(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

''(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

''(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

''(10) PUBLIC REPORTING.—

''(A) HOSPITAL SPECIFIC INFORMATION.—

''(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

''(I) the performance of the hospital with respect to each measure that applies to the hospital;

''(II) the performance of the hospital with respect to each condition or procedure; and

''(III) the hospital performance score assessing the total performance of the hospital.

''(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

''(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

''(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

''(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

''(11) IMPLEMENTATION.—

''(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

''(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

''(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

''(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

''(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

''(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

''(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

''(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

''(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).''.

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: ''The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).'';

(B) in subclause (V), by striking ''beginning with fiscal year 2008'' and inserting ''for fiscal years 2008 through 2012'';

(C) in subclause (VII), in the first sentence, by striking ''data submitted'' and inserting ''information regarding measures submitted''; and

(D) by adding at the end the following new subclauses:

''(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

''(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

''(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

''(aa) physicians under section 1848(k); and

''(bb) other providers of services and suppliers under this title.

''(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this

clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.''.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

''(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

''(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.''.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ''applicable hospital'' means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''2010'' and inserting ''2014''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

''(iii) for 2011, 1.0 percent; and

''(iv) for 2012, 2013, and 2014, 0.5 percent.'';

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period''; and

(B) in subparagraph (C)(i), by inserting '', or, for purposes of subsection (a)(8), for a quality reporting period for the year'' after ''(a)(5), for a reporting period for a year'';

(3) in paragraph (5)(E)(iv), by striking ''subsection (a)(5)(A)'' and inserting ''paragraphs (5)(A) and (8)(A) of subsection (a)''; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking '', 2009, 2010, and 2011'' and inserting ''and subsequent years''; and

(B) in clause (iii)—

(i) by inserting ''(a)(8)'' after ''(a)(5)''; and

(ii) by striking ''under subparagraph (D)(iii) of such subsection'' and inserting ''under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively''.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(8) INCENTIVES FOR QUALITY REPORTING.—

''(A) ADJUSTMENT.—

''(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2015, 98.5 percent; and

''(II) for 2016 and each subsequent year, 98 percent.

''(B) APPLICATION.—

''(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

''(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

''(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

''(iii) QUALITY REPORTING PERIOD.—The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary.''.

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting ''or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry'' after ''Database)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The selection of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) quality of care furnished to an individual.

''(B) Such other activities as specified by the Secretary.''.

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

''(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.''.

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ''There shall'' and inserting ''Except as provided in subparagraph (I), there shall''; and

(2) by adding at the end the following new subparagraph:

''(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking ''GENERAL.—The Secretary'' and inserting ''GENERAL.—

''(i) ESTABLISHMENT.—The Secretary'';

(ii) in clause (i), as added by clause (i), by striking ''the 'Program')'' and all that follows through the period at the end of the second sentence and inserting ''the 'Program').''; and

(iii) by adding at the end the following new clauses:

''(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

''(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.''; and

(B) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(ii)'';

(2) in paragraph (4)—

(A) in the heading, by inserting ''INITIAL'' after ''FOCUS''; and

(B) in the matter preceding subparagraph (A), by inserting ''initial'' after ''focus the'';

(3) in paragraph (6), by adding at the end the following new sentence: ''For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.''; and

(4) by adding at the end the following new paragraphs:

''(9) REPORTS ON UTILIZATION.—

''(A) DEVELOPMENT OF EPISODE GROUPER.—

''(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

''(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

''(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

''(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

''(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

''(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

''(i) attribute episodes of care, in whole or in part, to physicians;

''(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

''(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

''(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

''(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

''(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

''(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

''(i) the methodologies established under subparagraph (C);

''(ii) information regarding any adjustments made to data under subparagraph (D); and

''(iii) aggregate reports with respect to physicians.

''(F) DEFINITION OF PHYSICIAN.—In this paragraph:

''(i) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

''(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

''(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

''(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.''.

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

''(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.''.

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

''(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.''.

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).''; and

(2) by adding at the end the following new subsection:

''(k) QUALITY REPORTING BY CANCER HOSPITALS.—

''(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

''(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year,

each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(3) QUALITY MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

''(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

''(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1), by inserting ''subject to subsection (p),'' after ''1998,''; and

(2) by adding at the end the following new subsection:

''(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

''(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

''(2) QUALITY.—

''(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

''(B) MEASURES.—

''(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

''(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

''(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

''(4) IMPLEMENTATION.—

''(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

''(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

''(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

''(iii) The initial performance period (as specified under subparagraph (B)(ii)).

''(B) DEADLINES FOR IMPLEMENTATION.—

''(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

''(ii) INITIAL PERFORMANCE PERIOD.—

''(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

''(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

''(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

''(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

''(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

''(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

''(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

''(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) COSTS.—The term 'costs' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

''(B) PERFORMANCE PERIOD.—The term 'performance period' means a period specified by the Secretary.

''(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

''(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the establishment of the value-based payment modifier under this subsection;

''(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

''(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

''(D) the dates for implementation of the value-based payment modifier;

''(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

''(F) the application of the value-based payment modifier under paragraph (7); and

''(G) the determination of costs under paragraph (8)(A).''.

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

''(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

''(2) APPLICABLE HOSPITALS.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'applicable hospital' means a subsection (d) hospital that meets the criteria described in subparagraph (B).

''(B) CRITERIA DESCRIBED.—

''(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

''(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

''(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

''(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term 'hospital acquired condition' means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

''(4) APPLICABLE PERIOD.—In this subsection, the term 'applicable period' means, with respect to a fiscal year, a period specified by the Secretary.

''(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The criteria described in paragraph (2)(A).

''(B) The specification of hospital acquired conditions under paragraph (3).

''(C) The specification of the applicable period under paragraph (4).

''(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).''.

(b) STUDY AND REPORT ON EXPANSION OF HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER PROVIDERS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) REPORT.—Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART S—HEALTH CARE QUALITY PROGRAMS

''Subpart I—National Strategy for Quality Improvement in Health Care

''SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

''(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

''(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

''(2) IDENTIFICATION OF PRIORITIES.—

''(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

''(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

''(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

''(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

''(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

''(iv) improve Federal payment policy to emphasize quality and efficiency;

''(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

''(vi) address the health care provided to patients with high-cost chronic diseases;

''(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

''(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

''(ix) address other areas as determined appropriate by the Secretary.

''(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

''(D) COORDINATION WITH STATE AGENCIES.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

''(b) STRATEGIC PLAN.—

''(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

''(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

''(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

''(B) Agency-specific strategic plans to achieve national priorities.

''(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

''(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

''(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

''(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

''(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

''(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

''(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

''(2) UPDATES.—

''(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

''(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

''(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

''(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

''(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

''(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

''(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

''(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

''(1) the national priorities for health care quality improvement established under subsection (a)(2);

''(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

''(3) other information, as the Secretary determines to be appropriate.''.

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the ''Working Group'').

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Office of the National Coordinator for Health Information Technology;

(I) the Substance Abuse and Mental Health Services Administration;

(J) the Administration for Children and Families;

(K) the Department of Commerce;

(L) the Office of Management and Budget;

(M) the United States Coast Guard;

(N) the Federal Bureau of Prisons;

(O) the National Highway Traffic Safety Administration;

(P) the Federal Trade Commission;

(Q) the Social Security Administration;

(R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE-CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

(a) PUBLIC HEALTH SERVICE ACT.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking ''931'' and inserting ''941''; and

(4) by inserting after section 926 the following:

''PART D—HEALTH CARE QUALITY IMPROVEMENT

''Subpart I—Quality Measure Development

''SEC. 931. QUALITY MEASURE DEVELOPMENT.

''(a) QUALITY MEASURE.—In this subpart, the term 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

''(b) IDENTIFICATION OF QUALITY MEASURES.—

''(1) IDENTIFICATION.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

''(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

''(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

''(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

''(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

''(c) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

''(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

''(A) health outcomes and functional status of patients;

''(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

''(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to

inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

''(D) the meaningful use of health information technology;

''(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

''(F) the efficiency of care;

''(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

''(H) patient experience and satisfaction;

''(I) the use of innovative strategies and methodologies identified under section 933; and

''(J) other areas determined appropriate by the Secretary.

''(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

''(B) have adopted procedures to include in the quality measure development process—

''(i) the views of those providers or payers whose performance will be assessed by the measure; and

''(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

''(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

''(D) have transparent policies regarding governance and conflicts of interest; and

''(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

''(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

''(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

''(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

''(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

''(D) Each quality measure is free of charge to users of such measure.

''(E) Each quality measure is publicly available on an Internet website.

''(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

''(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act.''.

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection:

''(e) DEVELOPMENT OF QUALITY MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined appropriate by the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.''.

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, $75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

''(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

''(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

''(i) the selection of quality measures described in subparagraph (B), from among—

''(I) such measures that have been endorsed by the entity; and

''(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

''(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

''(B) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

''(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

''(II) for use in reporting performance information to the public; and

''(III) for use in health care programs other than for use under this Act.

''(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

''(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

''(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

''(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).''.

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

''(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

''(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

''(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).''.

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following:

''QUALITY MEASUREMENT

''SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a prerulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

''(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

''(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

''(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

''(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

''(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

''(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

''(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

''(B) make such assessment available to the public.

''(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

''(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

''(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

''(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

''(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall—

''(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

''(B) with respect to each such measure, determine whether to—

''(i) maintain the use of such measure; or

''(ii) phase out such measure.

''(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

''(A) seek to avoid duplication of measures used; and

''(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B.''.

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011, is further amended by adding at the end the following:

''SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

''(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

''(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be—

''(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

''(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

''(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

''(B) promote the use of the systems that provide data to improve and coordinate patient care;

''(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

''(D) agree to report, as determined by the Secretary, measures on quality and resource use to the public in accordance with the public reporting process established under section 399JJ.

''(c) CONSISTENT DATA AGGREGATION.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

''(d) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

''SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

''(a) DEVELOPMENT OF PERFORMANCE WEBSITES.—The Secretary shall make available to the public, through standardized Internet websites, performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

''(b) INFORMATION ON CONDITIONS.—The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

''(c) CONSULTATION.—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

''(2) CONSULTATION WITH STAKEHOLDERS.—The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available under subsection (a) and shall transmit to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

''(d) COORDINATION.—Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

''CENTER FOR MEDICARE AND MEDICAID INNOVATION

''SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

''(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

''(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

''(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

''(4) DEFINITIONS.—In this section:

''(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

''(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

''(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

''(iii) an individual who meets the criteria of both clauses (i) and (ii).

''(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

''(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

''(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

''(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

''(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

''(I) An inability to perform 2 or more activities of daily living.

''(II) Cognitive impairment, including dementia.

''(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

''(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

''(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

''(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

''(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

''(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

''(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

''(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

''(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

''(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

''(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

''(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

''(I) developing, documenting, and disseminating best practices and proven care methods;

''(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

''(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

''(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

''(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

''(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

''(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

''(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

''(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

''(iii) Whether the model provides for in-person contact with applicable individuals.

''(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

''(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

''(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

''(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

''(3) BUDGET NEUTRALITY.—

''(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

''(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

''(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

''(ii) reduce spending under the applicable title without reducing the quality of care; or

''(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(4) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

''(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

''(ii) the changes in spending under the applicable titles by reason of the model.

''(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

''(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected to—

''(A) reduce spending under applicable title without reducing the quality of care; or

''(B) improve the quality of care and reduce spending; and

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

''(d) IMPLEMENTATION.—

''(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

''(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the selection of models for testing or expansion under this section;

''(B) the selection of organizations, sites, or participants to test those models selected;

''(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(D) determinations regarding budget neutrality under subsection (b)(3);

''(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

''(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

''(f) FUNDING.—

''(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

''(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

''(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

''(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

''(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

''(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.''.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82) the following new paragraph:

''(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking ''5-year'' each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SHARED SAVINGS PROGRAM

''SEC. 1899. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

''(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

''(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

''(b) ELIGIBLE ACOS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

''(A) ACO professionals in group practice arrangements.

''(B) Networks of individual practices of ACO professionals.

''(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

''(D) Hospitals employing ACO professionals.

''(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

''(2) REQUIREMENTS.—An ACO shall meet the following requirements:

''(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

''(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

''(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

''(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

''(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

''(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

''(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

''(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

''(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

''(i) clinical processes and outcomes;

''(ii) patient and, where practicable, caregiver experience of care; and

''(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

''(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

''(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

''(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

''(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

''(A) A model tested or expanded under section 1115A that involves shared savings

under this title, or any other program or demonstration project that involves such shared savings.

''(B) The independence at home medical practice pilot program under section 1866E.

''(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

''(d) PAYMENTS AND TREATMENT OF SAVINGS.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

''(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

''(ii) the ACO meets the requirement under subparagraph (B)(i).

''(B) SAVINGS REQUIREMENT AND BENCHMARK.—

''(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

''(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

''(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

''(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

''(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

''(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

''(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

''(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(1) the specification of criteria under subsection (a)(1)(B);

''(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

''(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

''(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

''(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

''(6) the termination of an ACO under subsection (d)(4).

''(h) DEFINITIONS.—In this section:

''(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a practitioner described in section 1842(b)(18)(C)(i).

''(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY.—The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.''.

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

''NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

''SEC. 1866D. (a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

''(2) DEFINITIONS.—In this section:

''(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

''(ii) is admitted to a hospital for an applicable condition.

''(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

''(i) Whether the conditions selected include a mix of chronic and acute conditions.

''(ii) Whether the conditions selected include a mix of surgical and medical conditions.

''(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

''(iv) Whether a condition has significant variation in—

''(I) the number of readmissions; and

''(II) the amount of expenditures for post-acute care spending under this title.

''(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

''(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

''(C) APPLICABLE SERVICES.—The term 'applicable services' means the following:

''(i) Acute care inpatient services.

''(ii) Physicians' services delivered in and outside of an acute care hospital setting.

''(iii) Outpatient hospital services, including emergency department services.

''(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

''(v) Other services the Secretary determines appropriate.

''(D) EPISODE OF CARE.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'episode of care' means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

''(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

''(II) the length of stay of the applicable beneficiary in such hospital; and

''(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

''(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

''(E) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q).

''(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

''(G) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

''(H) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(5)(E).

''(I) SUPPLIER.—The term 'supplier' has the meaning given such term in section 1861(d).

''(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

''(b) DEVELOPMENTAL PHASE.—

''(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision

of post-acute care to the applicable beneficiary.

''(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.—

''(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

''(i) for episodes of care; and

''(ii) for post-acute care.

''(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

''(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

''(c) DETAILS.—

''(1) DURATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

''(B) EXTENSION.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

''(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

''(B) REQUIREMENTS.—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

''(3) PAYMENT METHODOLOGY.—

''(A) IN GENERAL.—

''(i) ESTABLISHMENT OF PAYMENT METHODS.—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

''(ii) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

''(B) INCLUSION OF CERTAIN SERVICES.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

''(C) BUNDLED PAYMENTS.—

''(i) IN GENERAL.—A bundled payment under the pilot program shall—

''(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

''(II) be made to the entity which is participating in the pilot program.

''(ii) REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.—Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

''(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

''(4) QUALITY MEASURES.—

''(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

''(i) Functional status improvement.

''(ii) Reducing rates of avoidable hospital readmissions.

''(iii) Rates of discharge to the community.

''(iv) Rates of admission to an emergency room after a hospitalization.

''(v) Incidence of health care acquired infections.

''(vi) Efficiency measures.

''(vii) Measures of patient-centeredness of care.

''(viii) Measures of patient perception of care.

''(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

''(B) REPORTING ON QUALITY MEASURES.—

''(i) IN GENERAL.—A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

''(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

''(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

''(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

''(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

''(A) improved quality measures established under subsection (c)(4)(A);

''(B) improved health outcomes;

''(C) improved applicable beneficiary access to care; and

''(D) reduced spending under this title.

''(2) REPORTS.—

''(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

''(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

''(f) CONSULTATION.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

''(g) IMPLEMENTATION PLAN.—

''(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

''(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.''.

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

''SEC. 1866D. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

''(A) reducing preventable hospitalizations;

''(B) preventing hospital readmissions;

''(C) reducing emergency room visits;

''(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

''(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

''(F) reducing the cost of health care services covered under this title; and

''(G) achieving beneficiary and family caregiver satisfaction.

''(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

''(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

''(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

''(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as

appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

''(ii) is organized at least in part for the purpose of providing physicians' services;

''(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

''(v) has entered into an agreement with the Secretary;

''(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

''(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

''(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

''(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

''(A) all the requirements of this section are met;

''(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

''(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

''(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

''(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

''(c) PAYMENT METHODOLOGY.—

''(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

''(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

''(d) APPLICABLE BENEFICIARIES.—

''(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

''(A) is entitled to benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

''(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

''(D) within the past 12 months has had a nonelective hospital admission;

''(E) within the past 12 months has received acute or subacute rehabilitation services;

''(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

''(G) meets such other criteria as the Secretary determines appropriate.

''(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

''(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

''(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

''(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

''(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

''(A) located in high-cost areas of the country;

''(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

''(C) use electronic medical records, health information technology, and individualized plans of care.

''(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

''(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(f) EVALUATION AND MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

''(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

''(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

''(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

''(i) TERMINATION.—

''(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

''(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

''(B) such practice fails to meet quality standards during any year of the demonstration program.

''(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an

independence at home medical practice for such other reasons determined appropriate by the Secretary.''.

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

''(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

''(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

''(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

''(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

''(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

''(3) ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

''(ii) the floor adjustment factor specified in subparagraph (C).

''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

''(i) fiscal year 2013 is 0.99;

''(ii) fiscal year 2014 is 0.98; or

''(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

''(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

''(ii) the number of admissions for such condition for such hospital for such applicable period; and

''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

''(C) EXCESS READMISSION RATIO.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

''(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

''(ii) measures of such readmissions—

''(I) have been endorsed by the entity with a contract under section 1890(a); and

''(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

''(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The determination of base operating DRG payment amounts.

''(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

''(C) The measures of readmissions as described in paragraph (5)(A)(ii).

''(8) READMISSION RATES FOR ALL PATIENTS.—

''(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

''(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

''(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—

''(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

''(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

''(D) DEFINITIONS.—For purposes of this paragraph:

''(i) The term 'all patients' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

''(ii) The term 'specified hospital' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.''.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

''SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

''(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

''(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

''(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.''.

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term ''high-risk Medicare beneficiary'' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) PROGRAM.—The term ''program'' means the program conducted under this section.

(5) READMISSION.—The term ''readmission'' has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act, as added by section 3025.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) REQUIREMENTS.—

(1) DURATION.—

(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) APPLICATION; PARTICIPATION.—

(A) IN GENERAL.—

(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2011''.

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''and (G)'' and inserting ''(G), and (H)''; and

(2) by adding at the end the following new subparagraph:

''(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

''(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

''(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

''(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

''(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

''(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and nonphysician staff wages, in different fee schedule areas.

''(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

''(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

''(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

''(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

''(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.''.

SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, and 2010''.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(A) by striking ''2007, and for'' and inserting ''2007, for''; and

(B) by striking ''2010'' and inserting ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,''; and

(2) in each of clauses (i) and (ii), by inserting '', and on or after April 1, 2010, and before January 1, 2011'' after ''January 1, 2010'' each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking ''2010'' and inserting ''2010, and on or after April 1, 2010, and before January 1, 2011''.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is further amended by striking ''3-year period'' each place it appears and inserting ''4-year period''.

(b) EXTENSION OF MORATORIUM.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking ''3-year period'' and inserting ''4-year period''.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking ''or clinical nurse specialist'' and inserting '', a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))'' after ''nurse practitioner''.

(2) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant'' after ''nurse practitioner,''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 100–275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting ''and subparagraph (G)'' after ''clause (ii)''; and

(B) by inserting '', except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011'' before the semicolon at the end; and

(2) by adding at the end the following new subparagraph:

''(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

''(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

''(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

''(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

''(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

''(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar

years, 3 fiscal years, or other yearly period specified by the Secretary.

''(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

''(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

''(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.''.

(b) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) RULE OF CONSTRUCTION.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

''(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

''(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

''(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting '', and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))'' before the period at the end; and

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

''(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

''(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

''(B) the conversion factor (established under subsection (d)) for 2006; and

''(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively.''; and

(B) in subsection (c)(2)(B)(iv)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.''.

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

(1) IN GENERAL.—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) REPORT.—An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3112. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking ''$22,290,000,000'' and inserting ''$0''.

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term ''complex diagnostic laboratory test'' means a diagnostic laboratory test—

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

(3) SEPARATE PAYMENT DEFINED.—In this section, the term ''separate payment'' means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

(b) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

(1) be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

(2) may not exceed $100,000,000.

(d) REPORT.—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

(2) such recommendations as the Secretary determines appropriate.

(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal

Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ''(or 100 percent for services furnished on or after January 1, 2011)'' after ''1992, 65 percent''.

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''2010''and inserting ''2011''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, or 2010''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: ''In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.''.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting ''or during the 1-year period beginning on July 1, 2010'' before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ONE-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

''(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section referred to as the '1-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

''(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

''(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

''(4) NO AFFECT ON HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural community hospital in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation.''.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by inserting ''(in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 1-year extension period'' after ''5-year period''.

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in paragraph (1)(B)(ii), by striking ''2)'' and inserting ''2))''; and

(B) in paragraph (2), by inserting ''cost'' before ''reporting period'' the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking ''paragraph (2)'' and inserting ''subparagraph (B)''; and

(B) in subparagraph (B), by striking ''paragraph (1)(B)'' and inserting ''subparagraph (A)(ii)''.

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(2) in clause (ii)(II), by striking ''October 1, 2011'' and inserting ''October 1, 2012''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(B) in clause (iv), by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting ''or (D)'' after ''subparagraph (B)'';

(2) in subparagraph (B), in the matter preceding clause (i), by striking ''The Secretary'' and inserting ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'';

(3) in subparagraph (C)(i)—

(A) by inserting ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles''; and

(B) by inserting ''(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''; and

(4) by adding at the end the following new subparagraph:

''(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.''.

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i–4 note) is amended by striking ''not more than 6''.

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS' SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).'';

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security

Act (42 U.S.C. 1395m) are each amended by inserting ''101 percent of'' before ''the reasonable costs''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking ''2010, and for'' and inserting ''2010, for''; and

(2) by inserting ''and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended'' before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(1) in subparagraph (A), by inserting ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end; and

(2) in subparagraph (E)—

(A) by striking '', and to offset'' and inserting '', to offset''; and

(B) by inserting ''and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking ''For periods'' and inserting ''Subject to clause (iii), for periods''; and

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

''(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

''(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

''(II) TRANSITION.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.''.

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking ''the aggregate'' and all that follows through the period at the end and inserting ''5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.''; and

(2) in paragraph (5)—

(A) by striking ''OUTLIERS.—The Secretary'' and inserting the following: ''OUTLIERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary'';

(B) in subparagraph (A), as added by subparagraph (A), by striking ''5 percent'' and inserting ''2.5 percent''; and

(C) by adding at the end the following new subparagraph:

''(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.''.

(c) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

(1) in the section heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and

(2) in subsection (a)—

(A) by striking '', and episodes'' and inserting '', episodes'';

(B) by inserting ''and episodes and visits ending on or after April 1, 2010, and before January 1, 2016,'' after ''January 1, 2007,''; and

(C) by inserting ''(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)'' before the period at the end.

(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REFORMS IN ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

(D) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)), as amended by section 3004(c), is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

''(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

''(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

''(i) charges and payments;

''(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

''(iii) with respect to each type of service included in hospice care—

''(I) the number of days of hospice care attributable to the type of service;

''(II) the cost of the type of service; and

''(III) the amount of payment for the type of service;

''(iv) charitable contributions and other revenue of the hospice program;

''(v) the number of hospice visits;

''(vi) the type of practitioner providing the visit; and

''(vii) the length of the visit and other basic information with respect to the visit.

''(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

''(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

''(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

''(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).''.

(2) CONFORMING AMENDMENTS.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)'' after ''subsequent fiscal year''; and

(ii) in subclause (VII), by inserting ''(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),'' after ''subsequent fiscal year''; and

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

''(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.''.

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION RECOMMENDATIONS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end; and

(2) by adding at the end the following new subparagraph:

''(D) on and after January 1, 2011—

''(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

''(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and''.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking ''For'' and inserting ''Subject to subsection (r), for''; and

(2) by adding at the end the following new subsection:

''(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

''(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

''(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

''(A) FACTOR ONE.—A factor equal to the difference between—

''(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

''(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

''(B) FACTOR TWO.—

''(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

''(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

''(II) who are uninsured in the most recent period for which data is available (as so calculated).

''(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

''(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

''(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

''(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

''(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

''(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

''(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

''(B) Any period selected by the Secretary for such purposes.''.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

''(K) POTENTIALLY MISVALUED CODES.—

''(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

''(L) VALIDATING RELATIVE VALUE UNITS.—

''(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

''(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

''(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

''(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

''(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

''(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

''(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

''(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

''(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

''(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

''(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).''.

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2013, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed $3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting ''subclause (III) and'' after ''Subject to''; and

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

''(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively.''; and

(2) in clause (iii)—

(A) in the heading, by inserting ''COMPLEX, REHABILITATIVE'' before ''POWER-DRIVEN''; and

(B) by inserting ''complex, rehabilitative'' before ''power-driven''.

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking ''(A)(ii) or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts

entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''September 30, 2009'' and inserting ''September 30, 2010''.

(2) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare'', including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 13951(t)) is amended by adding at the end the following new paragraph:

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(iii) by adding at the end the following new subparagraph:

''(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).''; and

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

''(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

''(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

''(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).''; and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

''(I) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection

(d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term ''urban Medicare-dependent hospital'' means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking ''AMOUNTS.—For purposes'' and inserting ''AMOUNTS.—

''(1) IN GENERAL.—For purposes'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking ''an amount equal to'' and all that follows through the end and inserting ''an amount equal to—

''(I) for years before 2007, 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

''(III) for 2012, the sum of—

''(aa) 2/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

''(IV) for 2013, the sum of—

''(aa) 1/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

''(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

''(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or'';

(iii) in clause (ii), as redesignated by clause (i), by striking ''subparagraph (A)'' and inserting ''clause (i)'';

(D) by adding at the end the following new paragraphs:

''(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

''(B) WEIGHTING RULES.—

''(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

''(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

''(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.''; and

(E) in subsection (k)(2)(B)(ii)(III), by striking ''(j)(1)(A)'' and inserting ''(j)(1)(A)(i)''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1853(k)(2) of the Social Security Act (42 U.S.C. 1395w–23(k)(2)) is amended—

(i) in subparagraph (A), by striking ''through 2010'' and inserting ''and subsequent years''; and

(ii) in subparagraph (C)—

(I) in clause (iii), by striking ''and'' at the end;

(II) in clause (iv), by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(v) for 2011 and subsequent years, 0.00.''.

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking ''1853(j)(1)'' and inserting ''1853(j)(1)(A)''; and

(ii) in paragraph (4)(B)(i), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''.

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) in paragraph (1), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''; and

(ii) in paragraph (3)(A), by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(D) Section 1860C–1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)) is amended—

(1) in clause (v), by striking ''and'' at the end;

(2) in clause (vi)—

(A) by striking ''for a year after 2002'' and inserting ''for 2003 through 2010''; and

(B) by striking the period at the end and inserting a comma; and

(C) by adding at the end the following new clauses:

''(vii) for 2011, 3 percentage points; and

''(viii) for a year after 2011, 0 percentage points.''.

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting ''(or 100 percent in the case of plan years beginning on or after January 1, 2014)'' after ''75 percent''.

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).''.

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking ''(iii) and (iv)'' and inserting ''(iii), (iv), and (v)''; and

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

''(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

''(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

''(aa) actuarial guidelines for the submission of bid information under this paragraph; and

''(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

''(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

''(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid

amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking ''MA REGION'' and inserting ''MA REGION; MA LOCAL PLAN SERVICE AREA'';

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

''(A) with respect to an MA local plan—

''(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

''(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and''; and

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

''(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

''(A) URBAN AREAS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

''(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

''(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

''(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

''(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)—

''(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

''(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.''.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''; and

(II) in subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as so defined)''.

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking ''Medicare Advantage payment area'' and inserting ''MA local area (as so defined)''.

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking ''a Medicare Advantage payment area that is''; and

(II) in subparagraph (D)(i), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''.

(v) Section 1854 of such Act (42 U.S.C. 1395w–24) is amended by striking subsection (h).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2012.

(f) PERFORMANCE BONUSES.—

(1) MA PLANS.—

(A) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(n) PERFORMANCE BONUSES.—

''(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

''(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

''(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

''(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

''(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

''(i) Care management programs that—

''(I) target individuals with 1 or more chronic conditions;

''(II) identify gaps in care; and

''(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

''(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

''(I) help manage chronic conditions;

''(II) reduce declines in health status; and

''(III) foster patient and provider collaboration.

''(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

''(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

''(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

''(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

''(vii) Medication therapy management programs that are more extensive than is required under section 1860D–4(c) (as determined by the Secretary).

''(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

''(ix) Such other care management and coordination programs as the Secretary determines appropriate.

''(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

''(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

''(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

''(2) QUALITY PERFORMANCE BONUSES.—

''(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

''(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year.

''(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

''(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

''(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

''(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

''(D) DATA USED IN DETERMINING SCORE.—

''(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

''(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

''(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

''(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1854(a)(1)(A) for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1851(e), and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

''(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

''(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

(i) in clause (i), by inserting ''and any performance bonus under subsection (n)'' before the period at the end; and

(ii) in clause (ii), by striking ''(G)'' and inserting ''(G), plus the amount (if any) of any performance bonus under subsection (n)''.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended—

(A) in subsection (f)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (i)''; and

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

''(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.''.

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLEES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (f), is amended by adding at the end the following new subsection:

''(o) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—

''(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

''(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

''(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

''(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

''(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

''(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

''(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

''(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

''(i) for 2012 and 2013, the sum of—

''(I) the bid amount under section 1854(a) for the MA local plan; and

''(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

''(ii) for 2014 and subsequent years, the sum of—

''(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

''(II) the applicable amount (as so defined) for the MA local plan for the year.

''(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

''(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

''(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1854(c) shall not apply with respect to the MA local plan.

''(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

''(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).''.

(h) TRANSITIONAL EXTRA BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

''(p) TRANSITIONAL EXTRA BENEFITS.—

''(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

''(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

''(A) enrolls in an MA local plan in an applicable area; and

''(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

''(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

''(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

''(B) A county where—

''(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

''(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

''(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for

the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

''(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

''(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

''(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.''.

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

''(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

''(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

''(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

''(3) Section 1853(n), relating to the payment of performance bonuses.

''(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

''(5) Section 1853(p), relating to transitional extra benefits.''.

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

''(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).''.

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by inserting '', subject to clause (iii),'' after ''and B or''; and

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

''(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

''(iv) SERVICES DESCRIBED.—The following services are described in this clause:

''(I) Chemotherapy administration services.

''(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

''(III) Skilled nursing care.

''(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

''(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (ii), by striking ''REBATE.—A rebate'' and inserting ''REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate'';

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

''(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

''(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

''(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

''(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).''.

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

''(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).''.

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking ''PREMIUM.—The term'' and inserting ''PREMIUM.—

''(i) IN GENERAL.—The term''; and

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

''(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).''.

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

''(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

''(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.''.

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

''(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D–1.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.''.

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients

and Providers Act of 2008 (Public Law 110–275), is amended by striking ''2011'' and inserting ''2014''.

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following new clause:

''(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

''(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

''(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.''.

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

''(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

''(ii) the original medicare fee-for-service program under parts A and B.

''(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

''(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

''(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

''(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

''(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.''.

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(E) If applicable, the plan meets the requirement described in paragraph (7).'';

(3) in paragraph (4), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).''; and

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

''(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).''.

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

''(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

''(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

''(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

''(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.''.

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking ''described in subsection (b)(6)(B)(i)''.

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2010'' and inserting ''January 1, 2013''.

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject ''2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans'') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.

SEC. 3208. MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

''(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

''(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

''(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

''(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

''(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

''(C) REJECTION OF BIDS.—

''(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

''(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.''.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by

adding at the end the following new subsection:

''(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES.—

''(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

''(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.''.

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking '', and (w)'' and inserting ''(w), and (y)''.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

''CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

''SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

''(1) participate in the Medicare coverage gap discount program under section 1860D–14A;

''(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

''(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

''(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

''(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

''(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

''(d) DEFINITION OF MANUFACTURER.—In this section, the term 'manufacturer' has the meaning given such term in section 1860D–14A(g)(5).''.

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following new section:

''MEDICARE COVERAGE GAP DISCOUNT PROGRAM

''SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the 'program') by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

''(b) TERMS OF AGREEMENT.—

''(1) IN GENERAL.—

''(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

''(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

''(C) TIMING OF AGREEMENT.—

''(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

''(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

''(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

''(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

''(4) LENGTH OF AGREEMENT.—

''(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

''(B) TERMINATION.—

''(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

''(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

''(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

''(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

''(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

''(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

''(c) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

''(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

''(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

''(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

''(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

''(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

''(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

''(I) the negotiated price of the applicable drug; and

''(II) the discounted price of the applicable drug;

''(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

''(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

''(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

''(B) MONITORING COMPLIANCE.—

''(i) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

''(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

''(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

''(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

''(2) LIMITATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

''(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

''(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

''(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

''(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

''(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

''(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

''(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

''(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program instruction or otherwise.

''(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

''(e) ENFORCEMENT.—

''(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

''(2) CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

''(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

''(ii) 25 percent of such amount.

''(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

''(g) DEFINITIONS.—In this section:

''(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug—

''(A) is enrolled in a prescription drug plan or an MA–PD plan;

''(B) is not enrolled in a qualified retiree prescription drug plan;

''(C) is not entitled to an income-related subsidy under section 1860D–14(a);

''(D) is not subject to a reduction in premium subsidy under section 1839(i); and

''(E) who—

''(i) has reached or exceeded the initial coverage limit under section 1860D–2(b)(3) during the year; and

''(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

''(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

''(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and

''(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

''(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

''(iii) is provided through an exception or appeal.

''(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

''(A) with respect to claims for reimbursement submitted electronically, 14 days; and

''(B) with respect to claims for reimbursement submitted otherwise, 30 days.

''(4) DISCOUNTED PRICE.—

''(A) IN GENERAL.—The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

''(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

''(C) SPECIAL CASE FOR CERTAIN CLAIMS.—In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D–2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

''(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

''(6) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

''(7) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22(a)(2).''.

(c) INCLUSION IN INCURRED COSTS.—

(1) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking ''In applying'' and inserting ''Except as provided in subparagraph (E), in applying''; and

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

''(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A, regardless of whether part of such costs were paid by a manufacturer under such program.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to costs incurred on or after July 1, 2010.

(d) CONFORMING AMENDMENT PERMITTING PRESCRIPTION DRUG DISCOUNTS.—

(1) IN GENERAL.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (G);

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A.''.

(2) CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICAID.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by inserting '', or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A'' before the period at the end.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting '', determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)'' before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

''(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.''.

(b) AUTHORIZING THE SECRETARY TO AUTOENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMIS PREMIUMS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting ''except as provided in subparagraph (D),'' after ''shall include,''

(2) by adding at the end the following new subparagraph:

''(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

''(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

''(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).''.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such section 119 is amended by adding at the end the following new subsection:

''(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.''.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

''(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(i) FORMULARY REQUIREMENTS.—

''(I) IN GENERAL.—Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

''(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

''(ii) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

''(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

''(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

''(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the

following categories and classes of drugs shall be identified under clause (ii)(I):

''(I) Anticonvulsants.

''(II) Antidepressants.

''(III) Antineoplastics.

''(IV) Antipsychotics.

''(V) Antiretrovirals.

''(VI) Immunosuppressants for the treatment of transplant rejection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

''(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

''(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

''(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

''(i) the quotient obtained by dividing—

''(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

''(II) 25.5 percent; and

''(ii) the base beneficiary premium (as computed under paragraph (2)).

''(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

''(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

''(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

''(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

''(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

''(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

''(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

''(III) The monthly adjustment amount specified in subparagraph (B).

''(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

''(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.''.

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

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

''(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

''(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

''(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(C) by inserting after subparagraph (E) the following new subparagraph:

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting ''AND PART D BASE BENEFICIARY PREMIUM INCREASE'' after ''PART B PREMIUM SUBSIDY ADJUSTMENT'';

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''or increase under section 1860D–13(a)(7)'' after ''1839(i)''; and

(ii) in clause (vii), by inserting after ''subsection (i) of such section'' the following: ''or increase under section 1860D–13(a)(7) of such Act''; and

(C) in subparagraph (B)—

(i) by striking ''Return information'' and inserting the following:

''(i) IN GENERAL.—Return information'';

(ii) by inserting ''or increase under such section 1860D–13(a)(7)'' before the period at the end;

(iii) as amended by clause (i), by inserting ''or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase'' before the period at the end; and

(iv) by adding at the end the following new clause:

''(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

''(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve administrative appeals of such premium subsidy adjustment or increased premium, and

''(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).''.

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting ''or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932'' after ''1902(q)(1)(B))''.

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) IN GENERAL.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) DEFINITIONS.—In this section:

(1) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) SYSTEM.—The term ''system'' means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

''(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

''(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

''(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan under title XIX.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term ''covered part D drug'' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) COVERED OUTPATIENT DRUG.—The term ''covered outpatient drug'' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term ''Medicare Advantage organization'' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)(a)(1)).

(E) PDP SPONSOR.—The term ''PDP sponsor'' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 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.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)''; and

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

''(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

''(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

''(iii) the Secretary shall establish procedures, which may include a reconciliation

process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

''(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

''(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

''(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.''.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is further amended—

(1) in clause (i)(XX), by striking ''clause (viii)'' and inserting ''clauses (viii), (ix), (xi), and (xii)'';

(2) in the first sentence of clause (viii), by inserting ''of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))'' after ''one-quarter'';

(3) in the first sentence of clause (ix)(I), by inserting ''(determined without regard to clause (viii), (xi), or (xii))'' after ''clause (i)'' the second time it appears; and

(4) by adding at the end the following new clauses:

''(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

''(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

''(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

''(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

''(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point; and

''(II) subject to clause (xiii), for each of fiscal years 2012 through 2019, by 0.2 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

''(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking ''PERCENTAGE.—The term'' and inserting ''PERCENTAGE.—

''(i) IN GENERAL.—Subject to clause (ii), the term''; and

(2) by adding at the end the following new clause:

''(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.''.

(c) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraphs:

''(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

''(A) IN GENERAL.—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

''(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

''(B) SPECIAL RULE.—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(4) OTHER ADJUSTMENT.—

''(A) IN GENERAL.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

''(i) for each of rate years 2010 and 2011, 0.25 percentage point; and

''(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percentage point.

''(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''.

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking ''FACTOR.—For purposes'' and inserting ''FACTOR.—

''(i) IN GENERAL.—For purposes'';

(B) by inserting ''subject to clause (ii)'' before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

(C) by adding at the end the following new clause:

''(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

''(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.''; and

(2) by adding at the end the following new subparagraph:

''(D) OTHER ADJUSTMENT.—

''(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

''(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

''(II) subject to clause (ii), for each of fiscal years 2012 through 2019, 0.2 percentage point.

''(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(e) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (ii)(V), by striking ''clause (v)'' and inserting ''clauses (v) and (vi)''; and

(2) by adding at the end the following new clause:

''(vi) ADJUSTMENTS.—After determining the home health market basket percentage

increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

''(I) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.''.

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:

''(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

''(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

''(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

''(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

''(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(3) OTHER ADJUSTMENT.—

''(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

''(i) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point; and

''(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

''(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''.

(g) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3132, is amended by adding at the end the following new clauses:

''(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

''(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.5 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.5 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

(1) in clause (i)—

(A) by inserting ''(I)'' after ''(F)(i)''

(B) in subclause (I), as inserted by subparagraph (A)—

(i) by striking ''clause (ii)'' and inserting ''subclause (II) and clause (ii)''; and

(ii) by striking ''minus 1.0 percentage point''; and

(C) by adding at the end the following new subclause:

''(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.''; and

(2) in clause (ii)(II)—

(A) by striking ''The'' and inserting ''Subject to clause (i)(II), the''; and

(B) by striking ''clause (i) minus 1.0 percentage point'' and inserting ''clause (i)(I)''.

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv), by inserting ''and subparagraph (F) of this paragraph'' after ''(17)''; and

(2) by adding at the end the following new subparagraphs:

''(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

''(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

''(G) OTHER ADJUSTMENT.—

''(i) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

''(I) for each of 2010 and 2011, 0.25 percentage point; and

''(II) subject to clause (ii), for each of 2012 through 2019, 0.2 percentage point.

''(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(j) AMBULANCE SERVICES.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B)—

(A) by inserting '', subject to subparagraph (C) and the succeeding sentence of this paragraph,'' after ''increased''; and

(B) by striking the period at the end and inserting ''; and'';

(3) by adding at the end the following new subparagraph:

''(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(4) by adding at the end the following flush sentence:

''The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.''.

(k) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.''.

(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i)—

(A) by inserting '', subject to clause (iv),'' after ''year) by''; and

(B) by striking ''through 2013'' and inserting ''and 2010''; and

(2) by adding at the end the following new clause:

''(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

''(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.''.

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K)—

(A) by striking ''2011, 2012, and 2013,''; and

(B) by inserting ''and'' after the semicolon at the end;

(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:

''(L) for 2011 and each subsequent year—

''(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(3) by adding at the end the following flush sentence:

''The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.''.

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—

(1) in subparagraph (A)—

(A) in clause (ix), by striking ''and'' at the end;

(B) in clause (x)—

(i) by striking ''a subsequent year'' and inserting ''for each of 2007 through 2010''; and

(ii) by inserting ''and'' after the semicolon at the end;

(C) by adding at the end the following new clause:

''(xi) for 2011 and each subsequent year—

''(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(D) by adding at the end the following flush sentence:

''The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.''.

(o) OTHER ITEMS.—Section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)) is amended—

(1) in the first sentence, by striking ''Subject to'' and inserting ''(A) Subject to'';

(2) by striking the second sentence and inserting the following new subparagraph:

''(B) Any fee schedule established under this paragraph for such item or service shall be updated—

''(i) for years before 2011—

''(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

''(II) for items and services described in paragraph (2)(D) for 2009, section 1834(a)(14)(J) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

''(ii) for 2011 and subsequent years—

''(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(3) by adding at the end the following flush sentence:

''The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.''.

(p) NO APPLICATION PRIOR TO APRIL 1, 2010.—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''subject to paragraph (6),'' after ''subsection,'';

(2) in paragraph (3)(A)(i), by striking ''The applicable'' and inserting ''Subject to paragraph (6), the applicable'';

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

''(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

''(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

''(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.''.

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

''INDEPENDENT MEDICARE ADVISORY BOARD

''SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the 'Independent Medicare Advisory Board'.

''(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

''(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as 'a determination year') the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as 'an implementation year');

''(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as 'a proposal year') a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

''(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

''(c) BOARD PROPOSALS.—

''(1) DEVELOPMENT.—

''(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

''(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

''(2) PROPOSALS.—

''(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

''(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

''(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

''(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

''(iv) As appropriate, the proposal shall include recommendations to reduce Medicare

payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

''(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

''(vi) The proposal shall only include recommendations related to the Medicare program.

''(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

''(i) give priority to recommendations that extend Medicare solvency;

''(ii) include recommendations that—

''(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

''(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

''(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

''(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

''(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

''(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

''(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

''(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

''(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

''(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

''(3) TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT.—

''(A) IN GENERAL.—

''(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this section to the President on January 15 of each year (beginning with 2014).

''(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

''(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph;

''(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year; or

''(III) for proposal year 2019 and subsequent proposal years, a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in paragraph (8) exceeds the growth rate described in paragraph (6)(A)(i).

''(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

''(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

''(i) the recommendations described in paragraph (2)(A)(i);

''(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

''(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

''(iv) a legislative proposal that implements the recommendations; and

''(v) other information determined appropriate by the Board.

''(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

''(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, to but fails, to submit a proposal to the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

''(A) such proposal to the President; and

''(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

''(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

''(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

''(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

''(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

''(B) MEDICARE PER CAPITA GROWTH RATE.—

''(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

''(ii) REQUIREMENT.—The projection under clause (i) shall—

''(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

''(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

''(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

''(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

''(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

''(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

''(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

''(7) SAVINGS REQUIREMENT.—

''(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

''(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

''(i) the total amount of projected Medicare program spending for the proposal year; and

''(ii) the applicable percent for the implementation year.

''(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

''(i) in the case of—

''(I) implementation year 2015, 0.5 percent;

''(II) implementation year 2016, 1.0 percent;

''(III) implementation year 2017, 1.25 percent; and

''(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

''(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

''(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

''(d) CONGRESSIONAL CONSIDERATION.—

''(1) INTRODUCTION.—

''(A) IN GENERAL.—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

''(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

''(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

''(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

''(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

''(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

''(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

''(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

''(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

''(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

''(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

''(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

''(4) EXPEDITED PROCEDURE.—

''(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

''(B) AMENDMENT.—

''(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

''(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

''(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

''(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

''(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

''(C) CONSIDERATION BY THE OTHER HOUSE.—

''(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

''(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

''(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

''(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

''(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

''(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

''(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

''(I) is related only to the program under this title; and

''(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(D) SENATE LIMITS ON DEBATE.—

''(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

''(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

''(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

''(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(E) CONSIDERATION IN CONFERENCE.—

''(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

''(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

''(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

''(I) is related only to the program under this title; and

''(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

''(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

''(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(e) IMPLEMENTATION OF PROPOSAL.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

''(2) APPLICATION.—

''(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

''(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

''(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

''(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

''(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

''(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

''(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and

''(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

''(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

''(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

''(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

''(A) that is introduced in 2017 by not later than February 1 of such year;

''(B) which does not have a preamble;

''(C) the title of which is as follows: 'Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act'; and

''(D) the matter after the resolving clause of which is as follows: 'That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.'.

''(2) PROCEDURE.—

''(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

''(C) CONSIDERATION.—

''(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

''(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

''(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

''(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

''(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

''(i) The joint resolution of the other House shall not be referred to a committee.

''(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

''(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

''(II) the vote on final passage shall be on the joint resolution of the other House.

''(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

''(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

''(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

''(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

''(i) make any determinations under subsection (c)(6) after May 1, 2017; or

''(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

''(B) the Board shall not submit any proposals or advisory reports to Congress under this section after January 16, 2018; and

''(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

''(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

''(1) MEMBERSHIP.—

''(A) IN GENERAL.—The Board shall be composed of—

''(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

''(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services,

and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

''(B) QUALIFICATIONS.—

''(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmacoeconomics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

''(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

''(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

''(i) the majority leader of the Senate concerning the appointment of 3 members;

''(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

''(iii) the minority leader of the Senate concerning the appointment of 3 members; and

''(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

''(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

''(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

''(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

''(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

''(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

''(3) CHAIRPERSON.—

''(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

''(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

''(i) the appointment and supervision of personnel employed by the Board;

''(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

''(iii) the use and expenditure of funds.

''(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

''(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

''(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

''(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

''(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

''(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

''(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

''(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

''(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

''(i) POWERS OF THE BOARD.—

''(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

''(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

''(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

''(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

''(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

''(j) PERSONNEL MATTERS.—

''(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

''(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

''(3) STAFF.—

''(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

''(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

''(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(k) CONSUMER ADVISORY COUNCIL.—

''(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

''(2) MEMBERSHIP.—

''(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

''(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

''(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

''(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

''(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

''(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

''(l) DEFINITIONS.—In this section:

''(1) BOARD; CHAIRPERSON; MEMBER.—The terms 'Board', 'Chairperson', and 'Member' mean the Independent Medicare Advisory

Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

''(2) MEDICARE.—The term 'Medicare' means the program established under this title, including parts A, B, C, and D.

''(3) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

''(4) MEDICARE PROGRAM SPENDING.—The term 'Medicare program spending' means program spending under parts A, B, and D net of premiums.

''(m) FUNDING.—

''(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

''(A) for fiscal year 2012, $15,000,000; and

''(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

''(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.''.

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

''(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

''(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

''(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.''.

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

(i) Medicare beneficiary access to providers and items and services;

(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

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

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(2) by inserting after paragraph (3) the following:

''(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.''.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

''Subpart II—Health Care Quality Improvement Programs

''SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

''(a) PURPOSE.—The purposes of this section are to—

''(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

''(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

''(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), or any other relevant agency or department designated by the Director, shall—

''(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

''(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

''(A) best practices for quality improvement practices in the delivery of health care services; and

''(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

''(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

''(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

''(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

''(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

''(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

''(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

''(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

''(8) provide for the development of best practices in the delivery of health care services that—

''(A) have a high likelihood of success, based on structured review of empirical evidence;

''(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

''(C) are designed to be readily adapted by health care providers in a variety of settings; and

''(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

''(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children's health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

''(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

''(c) RESEARCH FUNCTIONS OF CENTER.—

''(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices

that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

''(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

''(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

''(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

''(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

''(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

''(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

''(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

''(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

''(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Entercoccus infections and other emerging infections; and

''(iii) practical methods for reducing preventable hospital admissions and readmissions;

''(G) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

''(H) identify and mitigate hazards by—

''(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

''(ii) using the results of such analyses to develop scientific methods of response to such events;

''(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

''(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

''(d) DISSEMINATION OF RESEARCH FINDINGS.—

''(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

''(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

''(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

''(1) the cost to Federal health programs;

''(2) consumer assessment of health care experience;

''(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

''(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

''(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

''(6) the evolution of meaningful use of health information technology, as defined in section 3000.

''(f) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act.

''(g) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

''SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

''(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), shall award—

''(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

''(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

''(b) ELIGIBLE ENTITIES.—

''(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

''(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

''(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(c) APPLICATION.—

''(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for a sustainable business model that may include a system of—

''(i) charging fees to institutions and providers that receive technical support from the entity; and

''(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

''(B) such other information as the Director may require.

''(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

''(i) financial cost, staffing requirements, and timeline for implementation; and

''(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

''(B) such other information as the Director may require.

''(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

''(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

''(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

''(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

''(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

''(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information

technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.''.

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 2703), in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term ''primary care'' means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after section 934 the following:

''SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 933 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

''(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

''(2) submit to the Secretary a plan for achieving long-term financial sustainability;

''(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

''(4) submit a plan for meeting the requirements under subsection (c); and

''(5) submit to the Secretary such other information as the Secretary may require.

''(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

''(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

''(2) formulating a medication treatment plan according to therapeutic goals agreed

upon by the prescriber and the patient or caregiver or authorized representative of the patient;

''(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

''(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

''(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

''(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

''(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

''(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

''(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

''(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

''(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

''(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

''(2) take any 'high risk' medications;

''(3) have 2 or more chronic diseases, as identified by the Secretary; or

''(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

''(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

''(f) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

''(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

''(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

''(2) assess changes in overall health care resource use by targeted individuals;

''(3) assess patient and prescriber satisfaction with MTM services;

''(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

''(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

''(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

''(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may, through the quality measure development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.''.

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting ''**FOR TRAUMA SYSTEMS**'' after ''**GRANTS**''; and

(B) in subsection (a), by striking ''Administrator of the Health Resources and Services Administration'' and inserting ''Assistant Secretary for Preparedness and Response'';

(2) by inserting after section 1203 the following:

''SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

''(b) ELIGIBLE ENTITY; REGION.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a State or a partnership of 1 or more States and 1 or more local governments; or

''(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

''(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

''(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

''(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

''(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

''(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

''(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

''(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

''(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

''(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

''(B) such other information as the Secretary may require.

''(e) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount

equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

''(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

''(4) the State and local legislation necessary to implement and to maintain the system;

''(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

''(6) recommendations on the utilization of available funding for future regionalization efforts.

''(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).''; and

(3) in section 1232—

(A) in subsection (a), by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated $24,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by inserting after subsection (c) the following:

''(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.''.

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

''SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

''(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

''(1) the basic science of emergency medicine;

''(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

''(3) the translation of basic scientific research into improved practice; and

''(4) the development of timely and efficient delivery of health services.

''(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

''(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

''(2) the role of pediatric emergency services as an integrated component of the overall health system;

''(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

''(4) pediatric training in professional education; and

''(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

''(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) TRAUMA CARE CENTERS.—

(1) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

''(1) to assist in defraying substantial uncompensated care costs;

''(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

''(3) to provide emergency relief to ensure the continued and future availability of trauma services.

''(b) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

''(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

''(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

''(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

''(A) CATEGORY A.—The criteria for category A are as follows:

''(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

''(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

''(B) CATEGORY B.—The criteria for category B are as follows:

''(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

''(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

''(C) CATEGORY C.—The criteria for category C are as follows:

''(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

''(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

''(4) TRAUMA CENTERS IN 1115 WAIVER STATES.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool or Safety Net Care Pool established through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

''(5) DESIGNATION.—The Secretary may not award a grant to a trauma center unless such trauma center is verified by the American College of Surgeons or designated by an equivalent State or local agency.

''(c) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

''(1) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

''(2) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.''.

(2) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 of the Public Health Service Act (42 U.S.C. 300d–42) is amended by striking subsections (a) and (b) and inserting the following:

''(a) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

''(1) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

''(2) PERCENTAGES.—The applicable percentages are as follows:

''(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

''(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

''(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

''(b) CORE MISSION AWARDS.—

''(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

''(A) reserve 25 percent of the amount allocated for core mission awards for Level III and Level IV trauma centers; and

''(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I and II trauma centers—

''(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply;

''(ii) for which—

''(I) annual uncompensated care costs exceed $10,000,000; or

''(II) at least 20 percent of emergency department visits are charity or self-pay or Medicaid patients; and

''(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

''(c) EMERGENCY AWARDS.—In awarding grants under section 1241(a)(3), the Secretary shall—

''(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downgrade service or growth in demand for trauma services exceeds capacity; and

''(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significant uncompensated care award program.''.

(3) CERTAIN AGREEMENTS.—Section 1243 of the Public Health Service Act (42 U.S.C. 300d–43) is amended by striking subsections (a), (b), and (c) and inserting the following:

''(a) MAINTENANCE OF FINANCIAL SUPPORT.—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

''(b) TRAUMA CARE REGISTRY.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.''.

(4) GENERAL PROVISIONS.—Section 1244 of the Public Health Service Act (42 U.S.C. 300d–44) is amended by striking subsections (a), (b), and (c) and inserting the following:

''(a) APPLICATION.—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

''(b) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

''(c) LIMITATION ON AMOUNT OF GRANT.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

''(d) ELIGIBILITY.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

''(e) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

''(f) MINIMUM ALLOWANCE.—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

''(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

''(1) make available—

''(A) 50 percent of such funds for category A trauma center grantees;

''(B) 35 percent of such funds for category B trauma center grantees; and

''(C) 15 percent of such funds for category C trauma center grantees; and

''(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

''(h) REPORT.—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.''.

(5) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

''SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.''.

(6) DEFINITION.—Part D of title XII of the Public Health Service Act (42 U.S.C. 300d–41 et seq.) is amended by adding at the end the following:

''SEC. 1246. DEFINITION.

''In this part, the term 'uncompensated care costs' means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.''.

(b) TRAUMA SERVICE AVAILABILITY.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

''PART H—TRAUMA SERVICE AVAILABILITY

''SEC. 1281. GRANTS TO STATES.

''(a) ESTABLISHMENT.—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

''(b) AWARDING OF GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

''(c) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

''(A) be—

''(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

''(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

''(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

''(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

''(2) LIMITATION.—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

''(d) USE OF FUNDS.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

''(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

''(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

''(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

''(4) Establishing new trauma services in underserved areas as defined by the State.

''(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

''(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

''(7) Enhancing trauma surge capacity at specific trauma centers.

''(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

''(9) Enhancing interstate trauma center collaboration.

''(e) LIMITATION.—

''(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

''(2) MAINTENANCE OF EFFORT.—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

''(f) DISTRIBUTION OF FUNDS.—The following shall apply with respect to grants provided in this part:

''(1) LESS THAN $10,000,000.—If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

''(2) LESS THAN $20,000,000.—If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

''(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

''(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

''SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.''.

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

''SEC. 936. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

''(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

''(b) DEFINITIONS.—In this section:

''(1) PATIENT DECISION AID.—The term 'patient decision aid' means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

''(2) PREFERENCE SENSITIVE CARE.—The term 'preference sensitive care' means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.

''(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

''(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

''(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. Such contract shall provide that the entity perform the duties described in paragraph (2).

''(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this section, the Secretary shall enter into the first contract under subparagraph (A).

''(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of 18 months (except such contract may be renewed after a subsequent bidding process).

''(2) DUTIES.—The following duties are described in this paragraph:

''(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

''(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

''(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

''(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

''(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

''(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

''(C) to educate providers on the use of such materials, including through academic curricula.

''(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

''(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

''(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

''(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

''(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

''(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

''(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

''(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

''(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

''(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

''(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decisionmaking through—

''(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

''(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

''(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

''(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

''(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

''(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

''(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

''(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.''.

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits

and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

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

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

''SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

''SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

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

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 1011. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

''(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.'';

(2) in subsection (e), by adding at the end the following:

''(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.''; and

(3) in subsection (m)—

(A) in paragraph (1), by striking ''and $3,500,000 for fiscal year 2010.'' and inserting ''$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''; and

(B) in paragraph (2), by striking ''2010'' and inserting ''2015''.

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this subtitle), there is authorized to be appropriated such sums as may be necessary to carry out this subtitle (and such amendments made by this subtitle).

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Group to the Council to be known as the ''Advisory Group on Prevention, Health Promotion, and Integrative and Public Health'' (hereafter referred to in this section as the ''Advisory Group''). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics; and

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (4).

(i) PERIODIC REVIEWS.—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the ''Fund''), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal

year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 915 of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a) and inserting the following:

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

''(2) DUTIES.—The duties of the Task Force shall include—

''(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

''(B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

''(C) improved integration with Federal Government health objectives and related target setting for health improvement;

''(D) the enhanced dissemination of recommendations;

''(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

''(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

''(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

''SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

''(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

''(b) DUTIES.—The duties of the Task Force shall include—

''(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

''(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

''(3) improved integration with Federal Government health objectives and related target setting for health improvement;

''(4) the enhanced dissemination of recommendations;

''(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

''(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

''(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110–373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and Medicare and Medicaid.

(f) PERSONALIZED PREVENTION PLANS.—

(1) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(g) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—

(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

(2) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States' efforts to increase awareness of coverage of obesity-related services.

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

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to awarding grants for school-based health centers that serve a large population of children eligible for medical assistance under the State Medicaid plan under title XIX of the Social Security Act or under a waiver of such plan or children eligible for child health assistance under the State child health plan under title XXI of that Act (42 U.S.C. 1397aa et seq.).

(4) LIMITATION ON USE OF FUNDS.—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary. No funds provided under a grant awarded under this section shall be used for expenditures for personnel or to provide health services.

(5) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2013, $50,000,000 for the purpose of carrying out this subsection. Funds appropriated under this paragraph shall remain available until expended.

(6) DEFINITIONS.—In this subsection, the terms ''school-based health center'' and ''sponsoring facility'' have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

(b) GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.—Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

''SEC. 399Z–1. SCHOOL-BASED HEALTH CENTERS.

''(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by school-based health centers, which shall include the following:

''(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

''(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

''(A) IN GENERAL.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

''(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

''(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

''(ii) include factors indicative of the health status of such children and adolescents of an area, including the ability of the residents of such area to pay for health services, the accessibility of such services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

''(3) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' means a health clinic that—

''(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the Social Security Act and is administered by a sponsoring facility (as defined in section 2110(c)(9)(B) of the Social Security Act);

''(B) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with established standards, community practice, reporting laws, and other State laws, including parental consent and notification laws that are not inconsistent with Federal law; and

''(C) does not perform abortion services.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as 'SBHCs') that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (a)(3)); and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

''(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

''(D) such other information as the Secretary may require.

''(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

''(1) The Secretary may give preference to applicants who demonstrate an ability to serve the following:

''(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

''(B) Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs.

''(C) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

''(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 4101 of the Patient Protection and Affordable Care Act.

''(e) WAIVER OF REQUIREMENTS.—The Secretary may—

''(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

''(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

''(f) USE OF FUNDS.—

''(1) FUNDS.—Funds awarded under a grant under this section—

''(A) may be used for—

''(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

''(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

''(iii) the management and operation of health center programs;

''(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

''(B) may not be used to provide abortions.

''(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

''(3) LIMITATIONS.—

''(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

''(B) NO OVERLAPPING GRANT PERIOD.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

''(g) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

''(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

''(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

''(i) EVALUATION.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

''(j) AGE APPROPRIATE SERVICES.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

''(k) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such individual is considered a minor under applicable State law.

''(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end the following:

''PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

''SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the 'campaign') that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

''(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—

''(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

''(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

''(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

''SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic of a hospital owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act), a health system provider, a private provider of dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children's oral health; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

''(d) USE OF INFORMATION.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 399LL.

''SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, such sums as may be necessary.''.

(b) SCHOOL-BASED SEALANT PROGRAMS.—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking ''may award grants to States and Indian tribes'' and inserting ''shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)''.

(c) ORAL HEALTH INFRASTRUCTURE.—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

''(d) ORAL HEALTH INFRASTRUCTURE.—

''(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the

Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.''.

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ''PRAMS'') as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ''tooth-level surveillance'' means a clinical examination where an examiner looks at each dental surface, on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(FF) personalized prevention plan services (as defined in subsection (hhh));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)''.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Annual Wellness Visit

''(hhh)(1) The term 'personalized prevention plan services' means the creation of a plan for an individual—

''(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

''(B) that—

''(i) takes into account the results of the health risk assessment; and

''(ii) may contain the elements described in paragraph (2).

''(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

''(A) The establishment of, or an update to, the individual's medical and family history.

''(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

''(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

''(D) Detection of any cognitive impairment.

''(E) The establishment of, or an update to, the following:

''(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered under this title.

''(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

''(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

''(G) Any other element determined appropriate by the Secretary.

''(3) A health professional described in this paragraph is—

''(A) a physician;

''(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

''(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

''(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

''(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

''(ii) may be furnished—

''(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

''(II) during an encounter with a health care professional;

''(III) through community-based prevention programs; or

''(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

''(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

''(C)(i) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

''(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

''(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

''(i) ensure that health risk assessments are accessible to beneficiaries; and

''(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

''(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

''(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

''(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

''(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary's coverage begins under part B, which shall include information regarding any relevant differences between such services.

''(H) The Secretary shall issue guidance that—

''(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

''(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than personalized prevention plan services (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(FF) (including administration of the health risk assessment) ,'' after ''(2)(EE),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),''.

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395x(ddd)) is amended—

(1) in the heading, by inserting ''; Preventive Services'' after ''Services'';

(2) in paragraph (1), by striking ''not otherwise described in this title'' and inserting ''not described in subparagraph (A) or (C) of paragraph (3)''; and

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

''(3) The term 'preventive services' means the following:

''(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

''(B) An initial preventive physical examination (as defined in subsection (ww)).

''(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).''.

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

(i) in subparagraph (T), by inserting ''(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)'' after ''80 percent'';

(ii) in subparagraph (W)—

(I) in clause (i), by inserting ''(if such subparagraph were applied, by substituting '100 percent' for '80 percent')'' after ''subparagraph (D)''; and

(II) in clause (ii), by striking ''80 percent'' and inserting ''100 percent'';

(iii) by striking ''and'' before ''(X)''; and

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 4103(c)(3)(A), is amended—

(i) by striking ''or'' before ''personalized prevention plan services''; and

(ii) by inserting before the period the following: '', or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 4103(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1)(W) or (1)(Y),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4103(c)(4), is amended—

(1) in paragraph (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.''; and

(2) by adding at the end the following new sentence: ''Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

''(1) modify—

''(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

''(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

''(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.''.

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

''(13) other diagnostic, screening, preventive, and rehabilitative services, including—

''(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

''(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

''(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;''.

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—

(1) by striking '', and (4)'' and inserting '', (4)''; and

(2) by inserting before the period the following: '', and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)''.

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))''; and

(2) by adding at the end the following:

''(bb)(1) For purposes of this title, the term 'counseling and pharmacotherapy for cessation of tobacco use by pregnant women' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) services recommended with respect to pregnant women in 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

''(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: '', except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation''.

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)'' after ''complicate the pregnancy''.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))'' after ''complicate the pregnancy''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.

(a) INITIATIVES.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) DURATION.—

(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

(3) PROGRAM DESCRIBED.—

(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

(i) Ceasing use of tobacco products.

(ii) Controlling or reducing their weight.

(iii) Lowering their cholesterol.

(iv) Lowering their blood pressure.

(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

(b) EDUCATION AND OUTREACH CAMPAIGN.—

(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

(d) EVALUATIONS AND REPORTS.—

(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term ''Medicaid beneficiary'' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle C—Creating Healthier Communities

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to

provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.

(ii) TYPES OF SCREENING ACTIVITIES.—Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition; and

(III) any other measures deemed appropriate by the Secretary.

(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population.

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) MECHANISM.—

(I) IDENTIFICATION AND DETERMINATION OF STATUS.—With respect to each individual with risk factors for or having heart disease, stroke, diabetes, or any other condition for which such individual was screened under subparagraph (C), a grantee under this section shall determine whether or not such individual is covered under any public or private health insurance program.

(II) INSURED INDIVIDUALS.—An individual determined to be covered under a health insurance program under subclause (I) shall be referred by the grantee to the existing providers under such program or, if such individual does not have a current provider, to a provider who is in-network with respect to the program involved.

(III) UNINSURED INDIVIDUALS.—With respect to an individual determined to be uninsured under subclause (I), the grantee's community-based clinical partner described in paragraph (4)(D) shall assist the individual in determining eligibility for available public coverage options and identify other appropriate community health care resources and assistance programs.

(iii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and help determine eligibility for other public programs.

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

(2) MEDICARE EVALUATION OF PREVENTION AND WELLNESS PROGRAMS.—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help Medicare beneficiaries (particularly beneficiaries that have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which Medicare beneficiaries who participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors;

(II) improve their ability to manage their chronic conditions; and

(III) reduce their utilization of health services and associated costs under the Medicare program for conditions that are amenable to improvement under such programs.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

(6) MEDICARE BENEFICIARY.—In this subsection, the term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title.

SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

''SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 24 months after the date of enactment of the Affordable Health Choices Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency

rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The standards issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

''(c) REVIEW AND AMENDMENT.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.).''.

SEC. 4204. IMMUNIZATIONS.

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

''(1) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

''(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

''(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary under this subsection.''.

(b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

''(m) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

''(2) STATE PLAN.—To be eligible for a grant under paragraph (1), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes the interventions to be implemented under the grant and how such interventions match with local needs and capabilities, as determined through consultation with local authorities.

''(3) USE OF FUNDS.—Funds received under a grant under this subsection shall be used to implement interventions that are recommended by the Task Force on Community Preventive Services (as established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) or other evidence-based interventions, including—

''(A) providing immunization reminders or recalls for target populations of clients, patients, and consumers;

''(B) educating targeted populations and health care providers concerning immunizations in combination with one or more other interventions;

''(C) reducing out-of-pocket costs for families for vaccines and their administration;

''(D) carrying out immunization-promoting strategies for participants or clients of public programs, including assessments of immunization status, referrals to health care providers, education, provision of on-site immunizations, or incentives for immunization;

''(E) providing for home visits that promote immunization through education, assessments of need, referrals, provision of immunizations, or other services;

''(F) providing reminders or recalls for immunization providers;

''(G) conducting assessments of, and providing feedback to, immunization providers;

''(H) any combination of one or more interventions described in this paragraph; or

''(I) immunization information systems to allow all States to have electronic databases for immunization records.

''(4) CONSIDERATION.—In awarding grants under this subsection, the Secretary shall consider any reviews or recommendations of the Task Force on Community Preventive Services.

''(5) EVALUATION.—Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of progress made toward improving immunization coverage rates among high-risk populations within the State.

''(6) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Affordable Health Choices Act, the Secretary shall submit to Congress a report concerning the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand such program.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.''.

(c) REAUTHORIZATION OF IMMUNIZATION PROGRAM.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended—

(1) in paragraph (1), by striking ''for each of the fiscal years 1998 through 2005''; and

(2) in paragraph (2), by striking ''after October 1, 1997,''.

(d) RULE OF CONSTRUCTION REGARDING ACCESS TO IMMUNIZATIONS.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to decrease children's access to immunizations.

(e) GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO VACCINES.—

(1) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the ability of Medicare beneficiaries who were 65 years of age or older to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act over the period since the establishment of such program. Such study shall include the following:

(A) An analysis and determination of—

(i) the number of Medicare beneficiaries who were 65 years of age or older and were eligible for a routinely recommended vaccination that was covered under part D;

(ii) the number of such beneficiaries who actually received a routinely recommended vaccination that was covered under part D; and

(iii) any barriers to access by such beneficiaries to routinely recommended vaccinations that were covered under part D.

(B) A summary of the findings and recommendations by government agencies, departments, and advisory bodies (as well as relevant professional organizations) on the impact of coverage under part D of routinely recommended adult immunizations for access to such immunizations by Medicare beneficiaries.

(2) REPORT.—Not later than June 1, 2011, the Comptroller General shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $1,000,000 for fiscal year 2010 to carry out this subsection.

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''; and

(2) in subitem (ii), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to

enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—

''(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

''(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

''(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

''(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

''(3) WELLNESS PLANS.—

''(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

''(i) Nutritional counseling.

''(ii) A physical activity plan.

''(iii) Alcohol and smoking cessation counseling and services.

''(iv) Stress management.

''(v) Dietary supplements that have health claims approved by the Secretary.

''(vi) Compliance assistance provided by a community health center employee.

''(B) RISK FACTORS.—Wellness plan risk factors shall include—

''(i) weight;

''(ii) tobacco and alcohol use;

''(iii) exercise rates;

''(iv) nutritional status; and

''(v) blood pressure.

''(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.''.

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

''(r)(1) An employer shall provide—

''(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

''(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

''(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

''(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship

by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

''(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.''.

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 4302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

''SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

''(a) DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

''(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

''(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

''(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

''(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

''(2) COLLECTION STANDARDS.—In collecting data described in paragraph (1), the Secretary or designee shall—

''(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

''(B) develop standards for the measurement of sex, primary language, and disability status;

''(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

''(i) collects self-reported data by the applicant, recipient, or participant; and

''(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

''(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

''(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

''(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

''(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

''(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

''(3) DATA MANAGEMENT.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

''(A) develop national standards for the management of data collected; and

''(B) develop interoperability and security systems for data management.

''(b) DATA ANALYSIS.—

''(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

''(c) DATA REPORTING AND DISSEMINATION.—

''(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

''(A) the Office of Minority Health;

''(B) the National Center on Minority Health and Health Disparities;

''(C) the Agency for Healthcare Research and Quality;

''(D) the Centers for Disease Control and Prevention;

''(E) the Centers for Medicare & Medicaid Services;

''(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

''(G) the Office of Rural Health;

''(H) other agencies within the Department of Health and Human Services; and

''(I) other entities as determined appropriate by the Secretary.

''(2) REPORTING OF DATA.—The Secretary shall report data and analyses described in (a) and (b) through—

''(A) public postings on the Internet websites of the Department of Health and Human Services; and

''(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

''(3) AVAILABILITY OF DATA.—The Secretary may make data described in (a) and (b) available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency's data user agreements.

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

''(e) PROTECTION AND SHARING OF DATA.—

''(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

''(A) all data collected pursuant to subsection (a) is protected—

''(i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033); and

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

''(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).

''(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).

''(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

''(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

''(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.''.

(b) ADDRESSING HEALTH CARE DISPARITIES IN MEDICAID AND CHIP.—

(1) STANDARDIZED COLLECTION REQUIREMENTS INCLUDED IN STATE PLANS.—

(A) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 2001(d), is amended—

(i) in paragraph 4), by striking ''and'' at the end;

(ii) in paragraph (75), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after paragraph (75) the following new paragraph:

''(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act.''.

(B) CHIP.—Section 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e)) is amended by adding at the end the following new paragraph:

''(7) Data collected and reported in accordance with section 3101 of the Public Health Service Act, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.''.

(2) EXTENDING MEDICARE REQUIREMENT TO ADDRESS HEALTH DISPARITIES DATA COLLECTION TO MEDICAID AND CHIP.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 2703 is amended by adding at the end the following new section:

''SEC. 1946. ADDRESSING HEALTH CARE DISPARITIES.

''(a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate approaches for the collection of data under this title and title XXI, to be performed in conjunction with existing quality reporting requirements and programs under this title and title XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

''(1) Protecting patient privacy.

''(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this title or title XXI.

''(3) Improving program data under this title and title XXI on race, ethnicity, sex, primary language, and disability status.

''(b) REPORTS TO CONGRESS.—

''(1) REPORT ON EVALUATION.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

''(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this title and title XXI; and

''(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on such bases.

''(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI based on analyses of the data collected under subsection (c).

''(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.''.

SEC. 4303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 4102, is further amended by adding at the end the following:

''PART U—EMPLOYER-BASED WELLNESS PROGRAM

''SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

''In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

''(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

''(A) measuring the participation and methods to increase participation of employees in such programs;

''(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

''(C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

''(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

''SEC. 399MM–1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

''(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

''(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

''SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

''The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

''SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

''Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.''.

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

''Subtitle C—Strengthening Public Health Surveillance Systems

''SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

''(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

''(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

''(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

''(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

''(4) developing and implementing prevention and control strategies.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

''(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

''(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

''(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).''.

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ''the Conference'').

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may

enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

''(ii) 12 additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

''(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

"SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

''(a) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

''(b) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

''(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

''(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

''(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

''(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

''(5) recent findings, developments, and improvements in the provision of pain care.

''(c) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

''(d) PAIN CARE DEFINED.—For purposes of this section the term 'pain care' means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

''(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.''.

Subtitle E—Miscellaneous Provisions

SEC. 4401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) FINDING.—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) SENSE OF CONGRESS.—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE V—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals;

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals; and

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 5002. DEFINITIONS.

(a) THIS TITLE.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ''allied health professional'' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ''healthcare career pathway'' means a

rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—

(A) LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ''State workforce investment board'' and ''local workforce investment board'', refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) POSTSECONDARY EDUCATION.—The term ''postsecondary education'' means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution.

(6) REGISTERED APPRENTICESHIP PROGRAM.—The term ''registered apprenticeship program'' means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

''(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term 'physician assistant education program' means an educational program in a public or private institution in a State that—

''(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

''(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.''; and

(2) by adding at the end the following:

''(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

''(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of an entity that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

''(14) CLINICAL SOCIAL WORKER.—The term 'clinical social worker' has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).

''(15) CULTURAL COMPETENCY.—The term 'cultural competency' shall be defined by the Secretary in a manner consistent with section 1707(d)(3).

''(16) DIRECT CARE WORKER.—The term 'direct care worker' has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1013], Nursing Assistants [31–1014], and Personal Care Aides [39–9021].

''(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—

''(A) with a population density less than 6 persons per square mile within the service area; and

''(B) with respect to which the distance or time for the population to access care is excessive.

''(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.

''(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).

''(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

''(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term 'mental health service professional' means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

''(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term 'one-stop delivery system' means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

''(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional child and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

''(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'racial and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.

''(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).''.

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ''means a'' and inserting ''means an accredited (as defined in paragraph 6)''; and

(B) by striking the period as inserting the following: ''where graduates are—

''(A) authorized to sit for the National Council Licensure EXamination-Registered Nurse (NCLEX-RN); or

''(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b).''; and

(2) by adding at the end the following:

''(16) ACCELERATED NURSING DEGREE PROGRAM.—The term 'accelerated nursing degree program' means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

''(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term 'bridge or degree completion program' means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor's of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.''.

Subtitle B—Innovations in the Health Care Workforce

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels

and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified

health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 761(b) of the Public Service Health Act (as amended by section 5103).

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

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

(3) GIFTS AND SERVICES.—The Commission may not accept gifts, bequeaths, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term ''health care workforce'' includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) HEALTH PROFESSIONALS.—The term ''health professionals'' includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 5102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) ESTABLISHMENT.—There is established a competitive health care workforce development grant program (referred to in this section as the ''program'') for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(b) FISCAL AND ADMINISTRATIVE AGENT.—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the ''Administration'') shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the ''Commission''), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) PLANNING GRANTS.—

(1) AMOUNT AND DURATION.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) ELIGIBILITY.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of

higher education, the recognized State federation of labor, the State public secondary education agency, the State P–16 or P–20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonable require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration's evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) REPORT.—

(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State's performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and an administration agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) IN GENERAL.—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) ELIGIBLE PARTNERSHIP DUTIES.—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the alignment of curricula for health care careers; and the access to quality career information and guidance and education and training opportunities;

(ii) in consultation with key stakeholders and regional leaders, take appropriate steps to reduce Federal, State, or local barriers to a comprehensive and coherent strategy, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, career planning information, retraining for dislocated workers, and as appropriate, requests for Federal program or administrative waivers;

(iii) develop, disseminate, and review with key stakeholders a preliminary statewide strategy that addresses short- and long-term health care workforce development supply versus demand;

(iv) convene State partnership members on a regular basis, and at least on a semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (c) $8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

''(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

''(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the 'National Center').

''(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

''(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

''(B) carry out the activities under section 792(a);

''(C) annually evaluate programs under this title;

''(D) develop and publish performance measures and benchmarks for programs under this title; and

''(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

''(3) COLLABORATION AND DATA SHARING.—

''(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

''(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

''(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

''(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

''(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

''(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

''(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

''(A) studying practice patterns; and

''(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

''(3) GUIDELINES.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

''(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—

''(A) NATIONAL CENTER.—To carry out subsection (b), there are authorized to be appropriated $7,500,000 for each of fiscal years 2010 through 2014.

''(B) STATE AND REGIONAL CENTERS.—To carry out subsection (c), there are authorized to be appropriated $4,500,000 for each of fiscal years 2010 through 2014.

''(C) GRANTS FOR LONGITUDINAL EVALUATIONS.—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''; and

(4) in paragraph (2), by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

(1) in subparagraph (A), by striking ''or'' at the end;

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).''.

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 748(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

''(5) recommend appropriation levels for programs under this title, except for programs under part C or D.''.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(B) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.''; and

(2) by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.''.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200''; and

(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.''.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking ''1986'' and inserting ''2000''; and

(2) in paragraph (3), by striking ''the date of enactment of the Nurse Training Amendments of 1979'' and inserting ''September 29, 1995''.

SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

''Subpart 3—Recruitment and Retention Programs

''SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

''(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

''(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

''(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

''(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than $35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

''(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

''(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

''(c) IN GENERAL.—

''(1) ELIGIBLE INDIVIDUALS.—

''(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term 'qualified health professional' means a licensed physician who—

''(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

''(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

''(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term 'qualified health professional' means a health care professional who—

''(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

''(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

''(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

''(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

''(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

''(B) the individual is a United States citizen or a permanent legal United States resident; and

''(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

''(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

''(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

''(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

''(3) demonstrate financial need.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).''.

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

''SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

''(B)(i) have graduated, during the preceding 10-year period, from an accredited educational institution in a State or territory and received a public health or health professions degree or certificate; and

''(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

''(2) be a United States citizen; and

''(3)(A) submit an application to the Secretary to participate in the Program;

''(B) execute a written contract as required in subsection (c); and

''(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

''(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') between the Secretary and an individual shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

''(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

''(A) 3 years; or

''(B) such longer period of time as determined appropriate by the Secretary and the individual;

''(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

''(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

''(5) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract; and

''(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than $105,000, the Secretary shall pay an amount that does not exceed ⅓ of the eligible loan balance for each year of obligated service of the individual.

''(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

''(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

''(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

''(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

''(A) in a Federal, State, local, or tribal public health agency; or

''(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) ALLIED HEALTH PROFESSIONAL.—The term 'allied health professional' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

''(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

''(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''.

SEC. 5206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking ''; or'' and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following:

''(8) public health workforce loan repayment programs; or''.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5204, is further amended by adding at the end the following:

''SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in degree or professional training programs for the purpose of enabling mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary

''(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.''.

SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 5208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

''SEC. 330A–1. GRANTS TO NURSE–MANAGED HEALTH CLINICS.

''(a) DEFINITIONS.—

''(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

''(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an NMHC; and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

''(B) an assurance that the NMHC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

''(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

''(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

''(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

''(2) other factors, as the Secretary determines appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''.

SEC. 5209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking ''not to exceed 2,800''.

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

''SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

''(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

''(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

''(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times

be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

''(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

''(b) ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

''(c) PURPOSE AND USE OF READY RESEARCH.—

''(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service's reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

''(2) USES.—The Ready Reserve Corps shall—

''(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

''(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

''(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

''(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

''(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.''.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

''SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

''(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

''(B) to provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

''(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

''(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

''(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

''(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;

''(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—

''(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

''(ii) developing tools and curricula relevant to patient-centered medical homes; and

''(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

''(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

''(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(b) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary may make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

''(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

''(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

''(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

''(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

''(B) substantially expanding such units or programs.

''(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

''(A) proposes a collaborative project between academic administrative units of primary care;

''(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

''(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

''(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

''(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

''(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

''(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

''(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or

''(I) provide training in cultural competency and health literacy.

''(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

''(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.''.

SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

''SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as

nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

''(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

''(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

''(d) ELIGIBLE INDIVIDUAL.—

''(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

''(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.''.

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 5302, the following:

''SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

''(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

''(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public heath dentistry, or dental hygiene;

''(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

''(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

''(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

''(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

''(G) to create a loan repayment program for faculty in dental programs; and

''(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(2) FACULTY LOAN REPAYMENT.—

''(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

''(i) individuals agree to serve full-time as faculty members; and

''(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

''(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

''(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

''(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

''(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

''(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

''(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

''(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

''(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

''(6) Qualified applicants that include educational activities in cultural competency and health literacy.

''(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

''(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

''(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

''(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

''(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.''.

SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended by adding at the end the following:

''SEC. 340G–1. DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—

''(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

''(2) DEFINITION.—The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

''(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

''(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be—

''(A) an institution of higher education, including a community college;

''(B) a public-private partnership;

''(C) a federally qualified health center;

''(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

''(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

''(F) a public hospital or health system;

''(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

''(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

''(2) DISBURSEMENT OF FUNDS.—

''(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

''(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

''(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

''(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

''(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.''.

SEC. 5305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

''(d) GERIATRIC WORKFORCE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

''(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

''(A) carry out the fellowship program described in paragraph (4); and

''(B) carry out 1 of the 2 activities described in paragraph (5).

''(4) FELLOWSHIP PROGRAM.—

''(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a 'fellowship') that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

''(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

''(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

''(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

''(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

''(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

''(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

''(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

''(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

''(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,800,000 for the period of fiscal year 2011 through 2014.

''(e) GERIATRIC CAREER INCENTIVE AWARDS.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to received an award under paragraph (1), an individual shall—

''(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology who is pursuing a doctorate or other advanced degree in geriatrics or related fields in an accredited health professions school; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) CONDITION OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under guidelines set by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal years 2011 through 2013.''.

(b) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act 294(c)) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(2) by striking paragraph (2) through paragraph (3) and inserting the following:

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under paragraph (1), an individual shall—

''(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

''(B) have completed an approved fellowship program in geriatrics or have completed specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

''(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

''(3) LIMITATIONS.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

''(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

''(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

''(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

''(4) MAINTENANCE OF EFFORT.—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting ''for individuals who are physicians'' after ''this section''; and

(ii) by inserting after the period at the end the following: ''The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.''; and

(B) by adding at the end the following:

''(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.''.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.''; and

(2) in subsection (e), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 5103) as section 757; and

(3) inserting after section 755 the following:

''SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

''(1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;

''(2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

''(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

''(1) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

''(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

''(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

''(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

''(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

''(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

''(d) PRIORITY.—

''(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

''(A) are accredited by the Council on Social Work Education;

''(B) have a graduation rate of not less than 80 percent for social work students; and

''(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

''(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

''(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

''(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

''(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

''(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

''(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

''(E) provide services through a community mental health program described in section 1913(b)(1).

''(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

''(1) $8,000,000 for training in social work in subsection (a)(1);

''(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

''(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

''(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).''.

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking ''sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)'' and inserting ''sections 751(b)(1)(A), 753(b), and 755(b)''.

SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) in paragraph (1), by striking ''for the purpose of'' and all that follows through the period at the end and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, 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, and for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the

Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

''(c) DISSEMINATION.—

''(1) IN GENERAL.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

''(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.''.

(b) TITLE VIII.—Section 807 of the Public Health Service Act (42 U.S.C. 296e–1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) by striking ''for the purpose of'' and all that follows through ''health care.'' and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, 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, and for other purposes determined as appropriate by the Secretary.''; and

(2) by redesignating subsection (b) as subsection (d);

(3) by inserting after subsection (a) the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

''(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.''; and

(4) in subsection (d), as so redesignated—

(A) by striking ''subsection (a)'' and inserting ''this section''; and

(B) by striking ''2001 through 2004'' and inserting ''2010 through 2015''.

SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking ''AND NURSE MIDWIFERY PROGRAMS''; and

(B) by striking ''and nurse midwifery'';

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

''(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

''(1) have as their objective the education of midwives; and

''(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.''.

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking ''**RETENTION**'' and inserting ''**QUALITY**'';

(2) in subsection (a)—

(A) in paragraph (1), by adding ''or'' after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking ''managed care, quality improvement'' and inserting ''coordinated care'';

(4) in subsection (g), by inserting '', as defined in section 801(2),'' after ''school of nursing''; and

(5) in subsection (h), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

''SEC. 831A. NURSE RETENTION GRANTS.

''(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

''(b) GRANTS FOR CAREER LADDER PROGRAM.—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

''(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

''(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

''(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

''(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

''(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

''(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection (or section 831(c) as such section existed on the day before the date of enactment of this section).

''(3) CONTINUATION OF AN AWARD.—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

''(d) OTHER PRIORITY AREAS.—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

''(e) REPORT.—The Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract will meet the priority need of the nursing workforce.

''(f) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.''.

SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 846(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: '', or in a accredited school of nursing, as defined by section 801(2), as nurse faculty''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 5305, as section 865; and

(B) by redesignating part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''ESTABLISHMENT'' and inserting ''SCHOOL OF NURSING STUDENT LOAN FUND''; and

(B) by inserting ''accredited'' after ''agreement with any'';

(2) in subsection (c)—

(A) in paragraph (2), by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;''; and

(B) in paragraph (3)(A), by inserting ''an accredited'' after ''faculty member in'';

(3) in subsection (e), by striking ''a school'' and inserting ''an accredited school''; and

(4) in subsection (f), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health

Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

''SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under this subsection.

''(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

''(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

''(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

''(A) payments may not exceed $10,000 per calendar year; and

''(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

''(3) for an individual who has completed a doctorate or equivalent degree in nursing—

''(A) payments may not exceed $20,000 per calendar year; and

''(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

''(d) BREACH OF AGREEMENT.—

''(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

''(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

''(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

''(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

''(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

''(1) is a United States citizen, national, or lawful permanent resident;

''(2) holds an unencumbered license as a registered nurse; and

''(3) has either already completed a master's or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

''(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended to read as follows:

''SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.''.

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

''(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

''(3) to educate and provide outreach regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;

''(4) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

''(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

''(B) with a high percentage of residents who suffer from chronic diseases; or

''(C) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker', as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and healthcare agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health;

''(F) by providing referral and follow-up services or otherwise coordinating care; and

''(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.''.

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5206, is further amended by adding at the end the following:

''SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

''(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

''(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

''(c) OTHER PROGRAMS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

''(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338I(j).

''(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

''(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

''(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

''(3) $5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

''(4) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).''.

SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

''SEC. 271. ESTABLISHMENT.

''(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

''(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the 'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

''(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

''(E) 100 behavioral and mental health professional students annually;

''(F) 100 physician assistant or nurse practitioner students annually; and

''(G) 50 pharmacy students annually.

''(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act.

''(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

''(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

''(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

''(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

''SEC. 272. ADMINISTRATION.

''(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

''(b) FACULTY.—

''(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

''(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

''(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

''(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

''(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

''(1) Postdoctoral, postgraduate, and technological programs.

''(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

''(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

''(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

''(f) AUTHORITY OF THE SURGEON GENERAL.—

''(1) IN GENERAL.—The Surgeon General is authorized—

''(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

''(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

''(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

''(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

''(E) to accept the voluntary services of guest scholars and other persons.

''(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track

to make outlays in advance of the enactment of budget authority for such outlays.

''(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

''(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

''SEC. 273. STUDENTS; SELECTION; OBLIGATION.

''(a) STUDENT SELECTION.—

''(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

''(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

''(ii) subject to subparagraph (B), the student agrees—

''(I) to accept the provision of such tuition and student stipend to the student;

''(II) to maintain enrollment at the Track until the student completes the course of study involved;

''(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

''(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

''(V) to serve for a period of time (referred to in this part as the 'period of obligated service') within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

''(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

''(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

''(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

''(2) TUITION AND STUDENT STIPEND.—

''(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

''(B) STIPEND.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

''(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

''(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

''(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

''(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

''(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

''(e) ELITE FEDERAL DISASTER TEAMS.—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public health emergencies, natural disasters, bioterrorism events, and other emergencies.

''(f) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

''SEC. 274. FUNDING.

''Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.''.

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 5401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

''(h) FORMULA FOR ALLOCATIONS.—

''(1) ALLOCATIONS.—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

''(A) IN GENERAL.—If the amounts appropriated under subsection (i) for a fiscal year are $24,000,000 or less—

''(i) the Secretary shall make available $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

''(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

''(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

''(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(B) FUNDING IN EXCESS OF $24,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

''(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

''(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(C) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

''(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $6,000,000 for grants under subsection (a) to health professions

schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

''(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for grants under this section.

''(3) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the school receives such a grant.

''(B) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the grant, expend the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) $50,000,000 for each of the fiscal years 2010 through 2015; and

''(2) and such sums as are necessary for each subsequent fiscal year.''.

SEC. 5402. HEALTH CARE PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(a)(1) of the Public Health Service Act (42 U.S.C. 293b(a)(1)) is amended by striking ''$20,000 of the principal and interest of the educational loans of such individuals.'' and inserting ''$30,000 of the principal and interest of the educational loans of such individuals.''.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a)) is amended by striking ''$37,000,000'' and all that follows through ''2002'' and inserting ''$51,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014''.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated, $5,000,000 for each of the fiscal years 2010 through 2014.''.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: ''For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''

SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

''SEC. 751. AREA HEALTH EDUCATION CENTERS.

''(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

''(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

''(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term 'Program' refers to the area health education center program.

''(b) ELIGIBLE ENTITIES; APPLICATION.—

''(1) ELIGIBLE ENTITIES.—

''(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term 'eligible entity' means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

''(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term 'eligible entity' means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

''(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—

''(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

''(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

''(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

''(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

''(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

''(E) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

''(F) Propose and implement effective program and outcomes measurement and evaluation strategies.

''(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

''(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

''(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

''(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

''(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

''(d) REQUIREMENTS.—

''(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

''(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an

entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

''(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

''(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

''(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

''(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

''(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

''(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

''(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

''(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

''(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

''(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

''(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

''(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

''(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(1).

''(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

''(h) PROJECT TERMS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

''(A) in the case of a program, 12 years; or

''(B) in the case of a center within a program, 6 years.

''(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

''(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

''(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

''(A) not more than 35 percent shall be used for awards under subsection (a)(1);

''(B) not less than 60 percent shall be used for awards under subsection (a)(2);

''(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

''(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

''(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

''(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.''.

(b) CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by striking section 752 and inserting the following:

''SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

''(b) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means an entity described in section 799(b).

''(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.''.

SEC. 5404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary may'' and inserting the following:

''(1) AUTHORITY.—The Secretary may'';

(B) by striking ''pre-entry preparation, and retention activities'' and inserting the following: ''stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities''; and

(2) in subsection (b)—

(A) by striking ''First'' and all that follows through ''including the'' and inserting ''National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations,''; and

(B) by inserting before the period the following: '', and other organizations determined appropriate by the Secretary''.

SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5313, is further amended by adding at the end the following:

''SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

''(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

''(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as 'Health Extension Agents').

''(3) DEFINITIONS.—In this section:

''(A) HEALTH EXTENSION AGENT.—The term 'Health Extension Agent' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

''(B) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and

practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

''(b) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.—

''(1) GRANTS.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as 'Hubs').

''(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

''(A) shall consist of, at a minimum, the State health department, the entity responsible for administering the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

''(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

''(c) STATE AND LOCAL ACTIVITIES.—

''(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

''(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

''(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

''(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

''(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

''(2) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

''(A) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

''(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

''(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

''(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

''(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

''(B) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

''(i) provide technical assistance, training, and organizational support for community health teams established under section 3602 of the Patient Protection and Affordable Care Act;

''(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

''(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

''(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

''(v) participate in other activities, as determined appropriate by the Secretary.

''(d) FEDERAL PROGRAM ADMINISTRATION.—

''(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

''(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

''(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

''(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

''(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

''(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

''(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.''.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is amended by adding at the end the following new subsection:

''(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) PRIMARY CARE PRACTITIONER.—The term 'primary care practitioner' means an individual—

''(i) who—

''(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

''(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

''(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

''(B) PRIMARY CARE SERVICES.—The term 'primary care services' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

''(i) 99201 through 99215.

''(ii) 99304 through 99340.

''(iii) 99341 through 99350.

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 13951), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

''(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) GENERAL SURGEON.—In this subsection, the term 'general surgeon' means a

physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1866(j).

''(B) MAJOR SURGICAL PROCEDURES.—The term 'major surgical procedures' means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

''(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (a)(2), is amended by striking ''Section 1833(x)'' and inserting ''Subsections (x) and (y) of section 1833'' in the last sentence.

(c) BUDGET-NEUTRALITY ADJUSTMENT.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

''(vii) ADJUSTMENT FOR CERTAIN PHYSICIAN INCENTIVE PAYMENTS.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1833(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 332(a)(1)(A) of the Public Health Service Act) as health professional shortage areas.''.

SEC. 5502. MEDICARE FEDERALLY QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.—

(1) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

''(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

''(1) DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

''(B) COLLECTION OF DATA AND EVALUATION.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph and paragraph (2), respectively, including the reporting of services using HCPCS codes.

''(2) IMPLEMENTATION.—

''(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

''(B) PAYMENTS.—

''(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 103 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

''(ii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this subparagraph increased by the percentage increase in the MEI (as defined in 1842(i)(3)) for the year involved.''.

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''or paragraph (8)'' before the period at the end; and

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

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(ii) EXCEPTIONS.—This subparagraph shall not apply to—

''(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

''(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

''(III) a hospital described in paragraph (4)(H)(v).

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

''(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

''(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

''(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

''(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

''(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

''(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

''(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

''(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

''(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

''(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

''(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

''(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

''(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

''(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

''(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

''(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

''(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

''(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

''(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(H) DEFINITIONS.—In this paragraph:

''(i) REFERENCE RESIDENT LEVEL.—The term 'reference resident level' means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act''.

SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(i) effective for cost reporting periods beginning before July 1, 2010, all the time;'';

(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting ''; and'';

(3) by inserting after clause (i), as so inserted, the following new clause:

''(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.''; and

(4) by adding at the end the following flush sentence:

''Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010''; and

(2) by inserting after clause (I), as inserted by paragraph (1), the following new subparagraph:

''(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking ''Such rules'' and inserting ''Subject to subparagraphs (J) and (K), such rules''; and

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

''(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

''(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(2) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

''(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

''(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

''(bb) Second, to hospitals located in the same State as the hospital that closed.

''(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

''(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

''(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

''(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

''(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.''.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 5503, is amended by striking ''subsections (h)(7) and (h)(8)'' and inserting ''subsections (h)(4)(H)(vi), (h)(7), and (h)(8)''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section 1395ww(h)).

(d) EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

(e) CONFORMING AMENDMENT.—Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)), as amended by section 5503(a), is amended by striking ''paragraph or paragraph (8)'' and inserting ''this paragraph, paragraph (8), or paragraph (4)(H)(vi)''.

SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

''SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

''(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

''(2) REQUIREMENTS.—

''(A) AID AND SUPPORTIVE SERVICES.—

''(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

''(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

''(B) CONSULTATION AND COORDINATION.—An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the 'National Apprenticeship Act') (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

''(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

''(3) REPORTS AND EVALUATION.—

''(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

''(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

''(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

''(B) ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

''(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

''(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

''(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

''(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary

assistance for needy families program funded under part A of title IV.

''(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

''(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

''(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

''(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

''(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

''(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

''(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

''(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

''(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decisionmakers in the case where a health care consumer has impaired decision-making capacity).

''(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

''(iv) Personal care skills.

''(v) Health care support.

''(vi) Nutritional support.

''(vii) Infection control.

''(viii) Safety and emergency training.

''(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

''(x) Self-Care.

''(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

''(i) The length of the training.

''(ii) The appropriate trainer to student ratio.

''(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

''(iv) Trainer qualifications.

''(v) Content for a 'hands-on' and written certification exam.

''(vi) Continuing education requirements.

''(4) APPLICATION AND SELECTION CRITERIA.—

''(A) IN GENERAL.—

''(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

''(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

''(I) implement the core training competencies described in paragraph (3)(A); and

''(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

''(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

''(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

''(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

''(ii) meet the selection criteria established under subparagraph (C); and

''(iii) meet such additional criteria as the Secretary may specify.

''(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

''(i) geographic and demographic diversity;

''(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

''(iii) that the existing training standards for personal or home care aides in each participating State—

''(I) are different from such standards in the other participating States; and

''(II) are different from the core training competencies described in paragraph (3)(A);

''(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

''(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

''(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

''(5) EVALUATION AND REPORT.—

''(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

''(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

''(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

''(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

''(B) REPORTS.—

''(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

''(i) is licensed or authorized to provide services in a participating State; and

''(ii) receives payment for services under title XIX.

''(B) PERSONAL CARE SERVICES.—The term 'personal care services' has the meaning given such term for purposes of title XIX.

''(C) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

''(D) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

''(c) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

''(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

''(d) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 5508. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), as amended by section 5303, is further amended by inserting after section 749 the following:

"SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

''(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

''(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

''(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

''(A) curriculum development;

''(B) recruitment, training and retention of residents and faculty:

''(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

''(D) faculty salaries during the development phase; and

''(2) technical assistance provided by an eligible entity.

''(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

''(3) TEACHING HEALTH CENTER.—

''(A) IN GENERAL.—The term 'teaching health center' means an entity that—

''(i) is a community based, ambulatory patient care center; and

''(ii) operates a primary care residency program.

''(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

''(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).

''(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).

''(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.

''(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(v) An entity receiving funds under title X of the Public Health Service Act.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.''.

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

''(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.''.

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers

"SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

''(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

''(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER PER RESIDENT AMOUNT.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

''(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(B) UPDATING RATE.—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

''(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

''(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

''(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

''(1) shall be in addition to any payments—

''(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act;

''(B) for direct graduate medical education costs under section 1886(h) of such Act; and

''(C) for direct costs of medical education under section 1886(k) of such Act;

''(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under subparagraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and

''(3) shall not include the time in which a resident is counted toward full-time equivalency by a hospital under paragraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

''(f) RECONCILIATION.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

''(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.

''(h) ANNUAL REPORTING REQUIRED.—

''(1) ANNUAL REPORT.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

''(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

''(B) The number of approved training positions for residents described in paragraph (4).

''(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

''(D) Other information as deemed appropriate by the Secretary.

''(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

''(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

''(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the 'base level of primary care residents' for a teaching health center is the level of such residents as of a base period.

''(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

''(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

''(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center's application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

''(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

''(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

''(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

''(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(j) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' means a residency or other post-graduate medical training program—

''(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

''(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' has the meaning given that term in section 749A.

''(3) QUALIFIED TEACHING HEALTH CENTER.—The term 'qualified teaching health center' has the meaning given the term 'teaching health center' in section 749A.''.

SEC. 5509. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

(4) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ''advanced practice registered nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term ''demonstration'' means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term ''eligible partners'' includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 5601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

''(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

''(A) For fiscal year 2010, $2,988,821,592.

''(B) For fiscal year 2011, $3,862,107,440.

''(C) For fiscal year 2012, $4,990,553,440.

''(D) For fiscal year 2013, $6,448,713,307.

''(E) For fiscal year 2014, $7,332,924,155.

''(F) For fiscal year 2015, $8,332,924,155.

''(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(i) one plus the average percentage increase in costs incurred per patient served; and

''(ii) one plus the average percentage increase in the total number of patients served.''.

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

''(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

''(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

''(i) nondiscrimination based on the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 5602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year''; and

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014''.

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et

seq.) is amended by adding at the end the following:

"SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

''(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

''(A) the provision, by qualified primary care professionals, of on site primary care services;

''(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

''(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

''(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

''(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

''(e) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

SEC. 5605. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.—–Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.—

(A) IN GENERAL.—–As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 5701. REPORTS.

(a) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) REPORTS BY RECIPIENTS OF FUNDS.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may require on activities carried out with such award, and the effectiveness of such activities.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 6001. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

(3) by adding at the end the following new subsection:

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on February 1, 2010; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

''(II) the nature and extent of all ownership and investment interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

''(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(II) if applicable, any such ownership or investment interest of the treating physician.

''(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

''(I) on any public website for the hospital; and

''(II) in any public advertising for the hospital.

''(D) ENSURING BONA FIDE INVESTMENT.—

''(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

''(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

''(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(I) the hospital discloses such fact to a patient; and

''(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

''(ii) The hospital has the capacity to—

''(I) provide assessment and initial treatment for patients; and

''(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under

which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

''(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

''(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

''(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

''(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

''(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

''(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

''(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

''(5) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(6) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than November 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

''(a) TRANSPARENCY REPORTS.—

''(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

''(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(i) The name of the covered recipient.

''(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

''(iii) The amount of the payment or other transfer of value.

''(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

''(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form of payment or other transfer of value (as defined by the Secretary).

''(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) consulting fees;

''(II) compensation for services other than consulting;

''(III) honoraria;

''(IV) gift;

''(V) entertainment;

''(VI) food;

''(VII) travel (including the specified destinations);

''(VIII) education;

''(IX) research;

''(X) charitable contribution;

''(XI) royalty or license;

''(XII) current or prospective ownership or investment interest;

''(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

''(XIV) grant; or

''(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

''(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

''(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

''(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

''(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or

designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(b) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—Not later than October 1, 2011, the Secretary shall establish procedures—

''(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

''(ii) for the Secretary to make such information submitted available to the public.

''(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

''(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

''(i) is searchable and is in a format that is clear and understandable;

''(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(vii) contains any other information the Secretary determines would be helpful to the average consumer;

''(viii) does not contain the National Provider Identifier of the covered recipient, and

''(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

''(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

''(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

''(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

''(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(II) Four calendar years after the date such payment or other transfer of value was made.

''(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

''(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

''(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

''(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

''(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

''(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

''(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

''(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

''(i) not of the type required to be disclosed or reported under this section;

''(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

''(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

''(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

''(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(6) COVERED RECIPIENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

''(i) A physician.

''(ii) A teaching hospital.

''(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(8) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

''(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

''(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

''(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

''(ii) Product samples that are not intended to be sold and are intended for patient use.

''(iii) Educational materials that directly benefit patients or are intended for patient use.

''(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(vii) Discounts (including rebates).

''(viii) In-kind items used for the provision of charity care.

''(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

''(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

''(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

''(11) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).''.

SEC. 6003. DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL FOR CERTAIN IMAGING SERVICES.

(a) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6002, is amended by inserting after section 1128G the following new section:

''SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

''(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

''(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(b) DEFINITIONS.—In this section:

''(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

''(A) which is subject to subsection (b) of such section 503; and

''(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

''(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.''.

SEC. 6005. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1150 the following new section:

''SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''(a) PROVISION OF INFORMATION.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a 'PBM') that manages prescription drug coverage under a contract with—

''(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan under part D of title XVIII; or

''(2) a qualified health benefits plan offered through an exchange established by a State under section 1311 of the Patient Protection and Affordable Care Act,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

''(b) INFORMATION DESCRIBED.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

''(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

''(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs))that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

''(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

''(c) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

''(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

''(2) To permit the Comptroller General to review the information provided.

''(3) To permit the Director of the Congressional Budget Office to review the information provided.

''(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

''(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.''.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

''(2) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(3) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(5) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

''(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

''SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

''(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

''(1) a skilled nursing facility (as defined in section 1819(a)); or

''(2) a nursing facility (as defined in section 1919(a)).

''(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

''(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

''(2) DEVELOPMENT OF REGULATIONS.—

''(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

''(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term 'compliance and ethics program' means, with respect to a facility, a program of the operating organization that—

''(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(B) includes at least the required components specified in paragraph (4).

''(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

''(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.''.

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

''(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

''(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)) is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

''(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

''(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

''(V) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(e) DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

(1) The documentation on nursing facilities that is available to the public.

(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

(3) General information on consumer rights with respect to nursing facilities.

(4) The nursing facility survey process (on a national and State-specific basis).

(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.

SEC. 6104. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 6105. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(f) STANDARDIZED COMPLAINT FORM.—

''(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

''(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

''(i) a resident of a facility; and

''(ii) any person acting on the resident's behalf.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(2) include resident census data and information on resident case mix;

''(3) include a regular reporting schedule; and

''(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;

(2) any problems associated with such system or its implementation; and

(3) how such system could be improved.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a 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.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a

number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the ''Special Focus Facility'' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration project under this section.

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

(h) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ''additional disclosable party'' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

''(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

''(2) RELOCATION.—

''(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

''(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

''(A) shall be subject to a civil monetary penalty of up to $100,000;

''(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

''(C) shall be subject to any other penalties that may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

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

(f) REPORT.—Not later than 9 months after the completion of the demonstration project,

the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 6121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 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

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly

or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resident abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1181. (a) DEFINITIONS.—In this section:

''(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

''(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

''(A) IN GENERAL.—The terms 'comparative clinical effectiveness research' and 'research' mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

''(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

''(3) CONFLICT OF INTEREST.—The term 'conflict of interest' means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual's decisions in matters related to the Institute or the conduct of activities under this section.

''(4) REAL CONFLICT OF INTEREST.—The term 'real conflict of interest' means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

''(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

''(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

''(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

''(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the 'Patient-Centered Outcomes Research Institute' (referred to in this section as the 'Institute') which is neither an agency nor establishment of the United States Government.

''(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

''(3) FUNDING OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the

'PCORTF') under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

''(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

''(d) DUTIES.—

''(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

''(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

''(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

''(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

''(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

''(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

''(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

''(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

''(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

''(i) CONTRACTS.—

''(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

''(aa) Appropriate agencies and instrumentalities of the Federal Government.

''(bb) Appropriate academic research, private sector research, or study-conducting entities.

''(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

''(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

''(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

''(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

''(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

''(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

''(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

''(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

''(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

''(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

''(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

''(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

''(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

''(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

''(3) DATA COLLECTION.—

''(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

''(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

''(4) APPOINTING EXPERT ADVISORY PANELS.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

''(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

''(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

''(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

''(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

''(6) ESTABLISHING METHODOLOGY COMMITTEE.—

''(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

''(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific

field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

''(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

''(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

''(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

''(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

''(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

''(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

''(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

''(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

''(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

''(C) USE OF EXISTING PROCESSES.—

''(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

''(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

''(8) RELEASE OF RESEARCH FINDINGS.—

''(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

''(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

''(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

''(iii) include limitations of the research and what further research may be needed as appropriate;

''(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

''(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

''(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

''(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

''(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

''(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

''(B) the research project agenda and budget of the Institute for the following year;

''(C) any administrative activities conducted by the Institute during the preceding year;

''(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

''(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

''(e) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

''(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

''(f) BOARD OF GOVERNORS.—

''(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

''(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

''(B) The Director of the National Institutes of Health (or the Director's designee).

''(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

''(i) 3 members representing patients and health care consumers.

''(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

''(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

''(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

''(v) 1 member representing quality improvement or independent health service researchers.

''(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

''(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

''(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

''(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

''(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to

compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

''(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

''(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

''(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

''(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

''(2) REVIEW AND ANNUAL REPORTS.—

''(A) REVIEW.—The Comptroller General of the United States shall review the following:

''(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

''(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

''(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

''(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

''(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

''(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

''(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

''(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

''(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

''(A) Information contained in research findings as specified in subsection (d)(9).

''(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducing such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

''(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

''(D) Subsequent comments received during each of the public comment periods.

''(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

''(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

''(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

''(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

''(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

''(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

''(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

''(j) RULES OF CONSTRUCTION.—

''(1) COVERAGE.—Nothing in this section shall be construed—

''(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

''(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.''.

(b) DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3606, is further amended by inserting after section 936 the following:

''SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.

''(a) IN GENERAL.—

''(1) DISSEMINATION.—The Office of Communication and Knowledge Transfer (referred to in this section as the 'Office') at the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality), in consultation with the National Institutes of Health, shall broadly disseminate the research findings that are published by the Patient Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the 'Institute') and other government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for profit, and academic sources.

''(2) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute's research findings and government-funded research relevant to comparative clinical effectiveness research to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases shall—

''(A) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and

''(B) not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

''(b) INCORPORATION OF RESEARCH FINDINGS.—The Office, in consultation with relevant medical and clinical associations, shall assist users of health information technology focused on clinical decision support

to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

''(c) FEEDBACK.—The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from making its research findings publicly available as required under section 1181(d)(8) of the Social Security Act.

''(e) TRAINING OF RESEARCHERS.—The Agency for Health Care Research and Quality, in consultation with the National Institutes of Health, shall build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. At a minimum, such training shall be in methods that meet the methodological standards adopted under section 1181(d)(9) of the Social Security Act.

''(f) BUILDING DATA FOR RESEARCH.—The Secretary shall provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

''(g) AUTHORITY TO CONTRACT WITH THE INSTITUTE.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this part, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and instrumentalities.''.

(c) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a), is amended by adding at the end the following new section:

''LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1182. (a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

''(b) Nothing in section 1181 shall be construed as—

''(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

''(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

''(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

''(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under title XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness.

''(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

''(2)(A) Paragraph (1) shall not be construed to—

''(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

''(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability, or terminal illness.

''(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

''(e) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.''.

(d) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a) and amended by subsection (c), is amended by adding at the end the following new section:

''TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

''SEC. 1183. (a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986, of the following:

''(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

''(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

''(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.''.

(e) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

''SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Patient-Centered Outcomes Research Trust Fund' (hereafter in this section referred to as the 'PCORTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—

''(1) APPROPRIATION.—There are hereby appropriated to the Trust Fund the following:

''(A) For fiscal year 2010, $10,000,000.

''(B) For fiscal year 2011, $50,000,000.

''(C) For fiscal year 2012, $150,000,000.

''(D) For fiscal year 2013—

''(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(ii) $150,000,000.

''(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

''(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

''(2) TRUST FUND TRANSFERS.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

''(3) LIMITATION ON TRANSFERS TO PCORTF.—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

''(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

''(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this paragraph.

''(c) TRUSTEE.—The Secretary of the Treasury shall be a trustee of the PCORTF.

''(d) EXPENDITURES FROM FUND.—

''(1) AMOUNTS AVAILABLE TO THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subject to paragraph (2), amounts in the

PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

''(2) TRANSFER OF FUNDS.—

''(A) IN GENERAL.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each of fiscal years 2011 through 2019 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

''(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

''(C) REQUIREMENTS.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

''(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

''(ii) 20 percent to the Secretary to carry out the activities described in such section 937.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary of the Treasury based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

''(f) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.''.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

''Sec. 9511. Patient-centered outcomes research trust fund.''.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B), such arrangement shall be treated as a specified health insurance policy, and the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by 1 or more employers for the benefit of their employees or former employees,

''(B) by 1 or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(f) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.''.

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: ''Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).'';

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

''(2) PROVIDER SCREENING.—

''(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

''(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

''(i) shall include a licensure check, which may include such checks across States; and

''(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

''(I) a criminal background check;

''(II) fingerprinting;

''(III) unscheduled and unannounced site visits, including preenrollment site visits;

''(IV) database checks (including such checks across States); and

''(V) such other screening as the Secretary determines appropriate.

''(C) APPLICATION FEES.—

''(i) INDIVIDUAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

''(I) for 2010, $200; and

''(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

''(ii) INSTITUTIONAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

''(I) for 2010, $500; and

''(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

''(iii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

''(iv) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

''(D) APPLICATION AND ENFORCEMENT.—

''(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX , or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

''(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

''(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

''(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

''(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

''(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

''(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

''(4) INCREASED DISCLOSURE REQUIREMENTS.—

''(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title , title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

''(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

''(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any

past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

''(B) DEFINITIONS.—In this paragraph:

''(i) IN GENERAL.—The term 'applicable provider of services or supplier' means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

''(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term 'obligated provider of services or supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

''(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

''(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

''(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

''(7) COMPLIANCE PROGRAMS.—

''(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

''(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

''(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.''.

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

''(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);''; and

(B) by adding at the end the following:

''(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

''(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

''(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

''(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

''(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

''(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

''(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

''(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

''(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

''(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

''(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

''(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

''(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

''(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

''(8) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.''.

(2) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date).

(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), is amended by inserting before the semicolon at the end the following: ''or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 2101(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N), respectively; and

(2) by inserting after subparagraph (C), the following:

''(D) Subsections (a)(77) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).''.

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002, 6004, and 6102, is amended by inserting after section 1128I the following new section:

''SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

''(a) DATA MATCHING.—

''(1) INTEGRATED DATA REPOSITORY.—

''(A) INCLUSION OF CERTAIN DATA.—

''(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

''(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

''(II) The program under title XXI.

''(III) Health-related programs administered by the Secretary of Veterans Affairs.

''(IV) Health-related programs administered by the Secretary of Defense.

''(V) The program of old-age, survivors, and disability insurance benefits established under title II.

''(VI) The Indian Health Service and the Contract Health Service program.

''(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

''(B) DATA SHARING AND MATCHING.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and

Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

''(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

''(I) The Commissioner of Social Security.

''(II) The Secretary of Veterans Affairs.

''(III) The Secretary of Defense.

''(IV) The Director of the Indian Health Service.

''(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

''(2) ACCESS TO CLAIMS AND PAYMENT DATABASES.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

''(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

''(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

''(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

''(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f)) regardless of how the item or service is paid for, or to whom such payment is made.

''(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under an MA–PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

''(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

''(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

''(2) APPLICABLE INDIVIDUAL.—For purposes of paragraph (1), the term 'applicable individual' means an individual—

''(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

''(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

''(C) eligible for child health assistance under a child health plan under title XXI.

''(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

''(1) IN GENERAL.—If a person has received an overpayment, the person shall—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

''(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

''(A) the date which is 60 days after the date on which the overpayment was identified; or

''(B) the date any corresponding cost report is due, if applicable.

''(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

''(4) DEFINITIONS.—In this subsection:

''(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

''(C) PERSON.—

''(i) IN GENERAL.—The term 'person' means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

''(ii) EXCLUSION.—Such term does not include a beneficiary.

''(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.''.

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–116(f)(2)) is amended by striking ''may be used by'' and all that follows through the period at the end and inserting ''may be used—

''(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

''(i) carrying out this section; and

''(ii) conducting oversight, evaluation, and enforcement under this title; and

''(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.''.

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking ''or'' at the end;

(B) in clause (viii), by inserting ''or'' after the semicolon; and

(C) by adding at the end the following new clause:

''(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records with non-Federal records;''.

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

''(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

''(B) For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.''.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

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

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

(3) by adding at the end the following new paragraph:.

''(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).''.

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.''.

(2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) in paragraph (1)(D), by striking ''was excluded'' and all that follows through the period at the end and inserting ''was excluded

from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.'';

(ii) in paragraph (6), by striking ''or'' at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

''(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

''(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

''(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;'';

(iv) in the first sentence—

(I) by striking the ''or'' after ''prohibited relationship occurs;''; and

(II) by striking ''act)'' and inserting ''act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)''; and

(v) in the second sentence, by striking ''purpose)'' and inserting ''purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact)''.

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(i) in subparagraph (C), by striking ''or'' at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting ''; or''; and

(iv) by adding at the end the following new subparagraphs:

''(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

''(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

''(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

''(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

''(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services are not offered as part of any advertisement or solicitation;

''(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

''(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

''(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

''(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.''.

(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a–7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.''.

(f) HEALTH CARE FRAUD.—

(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.''.

(2) REVISING THE INTENT REQUIREMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

''(h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the supplier'' before the period at the end.

(2) HOME HEALTH AGENCIES.—Section 1861(o)(7)(C) of the Social Security Act (42 U.S.C. 1395x(o)(7)(C)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the home health agency'' before the semicolon at the end.

(3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

''(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

''(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).''.

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

''(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

''(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

''(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

''(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1903(i)(2)(C).''.

(2) MEDICAID.—Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

(A) in subparagraph (A), by striking ''or'' at the end; and

(B) by inserting after subparagraph (B), the following:

''(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or''.

(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.''; and

(B) in paragraph (4)(A), by inserting ''until expended'' after ''appropriation''.

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting ''and'' at the end;

(ii) in subclause (IV)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (V).

(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(i) in subclause (VIII), by inserting ''and'' at the end;

(ii) in subclause (IX)—

(I) by striking ''for each of fiscal years 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2007''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting ''and'' at the end;

(ii) in clause (viii)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

''(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.''.

(j) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking ''and'' at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

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

''(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(i) EVALUATIONS AND ANNUAL REPORT.—

''(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

''(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

''(B) the effectiveness of the use of such funds.''.

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u–6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

(ii) by inserting after subparagraph (C) the following new subparagraph:

''(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u–7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

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

''(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.''.

(k) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) by striking subsection (a) and inserting the following:

''(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).'';

(2) by striking subsection (d) and inserting the following:

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.'';

(3) by striking subsection (f) and inserting the following:

''(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.''; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (iii)—

(I) by striking ''or State'' each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

''(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction''; and

(ii) by striking clause (iv) and inserting the following:

''(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).'';

(B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking ''or State''.

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r–2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''SYSTEM.—The State'' and all that follows through the semicolon and inserting SYSTEM.—

''(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:'';

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking ''the license of'' and inserting ''license or the right to apply for, or renew, a license by''; and

(II) by inserting ''nonrenewability,'' after ''voluntary surrender,''; and

(iv) by adding at the end the following new subparagraph:

''(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.''; and

(B) in paragraph (2), by striking ''the authority described in paragraph (1)'' and inserting ''a State licensing or certification agency or State law or fraud enforcement agency'';

(2) in subsection (b)—

(A) by striking paragraph (2) and inserting the following:

''(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;'';

(B) in each of paragraphs (4) and (6), by inserting '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

''(5) to State law or fraud enforcement agencies,'';

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

''(7) to health plans (as defined in section 1128C(c));'';

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

''(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

''(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

''(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

''(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

''(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

''(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

''(g) REFERENCES.—For purposes of this section:

''(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term 'State licensing or certification agency' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

''(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term 'State law or fraud enforcement agency' includes—

''(A) a State law enforcement agency; and

''(B) a State medicaid fraud control unit (as defined in section 1903(q)).

''(3) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'final adverse action' includes—

''(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

''(ii) State criminal convictions related to the delivery of a health care item or service;

''(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

''(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

''(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim.''; and

(4) in subsection (h), as so redesignated, by striking ''The Secretary'' and all that follows through the period at the end and inserting ''In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.''.

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding ''and'' after the comma at the end;

(2) in subparagraph (D), by striking '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(3) FUNDING.—

(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term ''transition period'' means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)(1)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(2) PART B.—

(A) Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended—

(i) in subparagraph (B), in the flush language following clause (ii), by striking ''close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)'' and inserting ''period ending 1 calendar year after the date of service''; and

(ii) by adding at the end the following new sentence: ''In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.''

(B) Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(i) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(ii) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed not later that December 31, 2010.

SEC. 6405. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section

1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j)''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting '', or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' after ''a physician''.

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph

''(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

(1) in subparagraph (U), by striking at the end ''and'';

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

(3) by adding at the end the following new subparagraph:

''(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

(1) by striking ''ORDER.—The Secretary'' and inserting ''ORDER.—

''(i) IN GENERAL.—The Secretary''; and

(2) by adding at the end the following new clause:

''(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking ''or'' at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

''(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

''(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(3) in the first sentence—

(A) by striking ''or in cases under paragraph (7)'' and inserting ''in cases under paragraph (7)''; and

(B) by striking ''act)'' and inserting ''act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)''.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(B) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)) is amended—

(A) in subparagraph (F), by striking ''or'' at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

''(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

''(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;''; and

(C) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.''.

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP''). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 6410. ADJUSTMENTS TO THE MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES COMPETITIVE ACQUISITION PROGRAM.

(a) EXPANSION OF ROUND 2 OF THE DME COMPETITIVE BIDDING PROGRAM.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(1) in subparagraph (B)(i)(II), by striking ''70'' and inserting ''91''; and

(2) in subparagraph (D)(ii)—

(A) in subclause (I), by striking ''and'' at the end;

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following new subclause:

''(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and''.

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by inserting ''(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)'' after ''may''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).''.

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ''that the records'' and inserting ''that—

''(A) the records'';

(B) by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(B) not later than December 31, 2010, the State shall—

''(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

''(ii) provide assurances satisfactory to the Secretary that—

''(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

''(II) from such amounts recovered, payment—

''(aa) shall be made on a contingent basis for collecting overpayments; and

''(bb) may be made in such amounts as the State may specify for identifying underpayments;

''(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

''(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

''(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

''(bb) that section 1903(d) shall apply to amounts recovered under the program; and

''(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and''.

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

''(A) ensure that each MA plan under part C has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(B) ensure that each prescription drug plan under part D has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

''(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.''.

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through

the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title,''.

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6401(b), is amended by inserting after paragraph (77) the following:

''(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period;''.

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 6502(a), is amended by inserting after paragraph (78), the following:

''(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;''.

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine''.

(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

''(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;''.

SEC. 6506. OVERPAYMENTS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking ''60 days'' and inserting ''1 year''; and

(ii) in the second sentence, by striking ''60 days'' and inserting ''1-year period''; and

(B) in subparagraph (D)—

(i) in inserting ''(i)'' after ''(D)''; and

(ii) by adding at the end the following:

''(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by adding ''and'' after the semi-colon; and

(C) by adding at the end the following new clause:

''(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

''(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

''(A) Not later than September 1, 2010:

''(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

''(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

''(iii) Notify States of—

''(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

''(II) how States are to incorporate such methodologies into claims filed under this title.

''(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).''.

SEC. 6508. GENERAL EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle G—Additional Program Integrity Provisions

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

''SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

''No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, or the representative or agent of any such person, State, or the Secretary, concerning—

''(1) the financial condition or solvency of such plan or arrangement;

''(2) the benefits provided by such plan or arrangement;

''(3) the regulatory status of such plan or other arrangement under any Federal or

State law governing collective bargaining, labor management relations, or intern union affairs; or

''(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).''.

(b) CRIMINAL PENALTIES.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' before ''Any person''; and

(2) by adding at the end the following:

''(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.''.

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

''Sec. 519. Prohibition on false statement and representations.''.

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting ''or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974,'' after ''1954 of this title''.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

''SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

''The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.''.

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

''SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

''The Secretary may, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1986, and regardless of whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).''.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

''Sec. 520. Applicability of State law to combat fraud and abuse.''.

SEC. 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.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

''SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

''(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

''(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under subsection (a) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

''(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under subsection (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

''(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order involved may be affirmed, modified, or set aside by the Secretary in whole or in part.

''(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

''(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

''(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).''.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6604, is further amended by adding at the end the following:

''Sec. 521. Administrative summary cease and desist orders and summary seizure orders against health plans in financially hazardous condition.''.

SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT OF LABOR.

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking ''Secretary may'' and inserting ''Secretary shall''; and

(2) by inserting ''to register with the Secretary prior to operating in a State and may, by regulation, require such multiple employer welfare arrangements'' after ''not group health plans''.

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 504 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

''(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

''(1) A State insurance department.

''(2) A State attorney general.

''(3) The National Association of Insurance Commissioners.

''(4) The Department of Labor.

''(5) The Department of the Treasury.

''(6) The Department of Justice.

''(7) The Department of Health and Human Services.

''(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

''(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.''.

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Elder Justice Act of 2009''.

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting ''**AND ELDER JUSTICE**'' after ''**SOCIAL SERVICES**'';

(B) by inserting before section 2001 the following:

''Subtitle A—Block Grants to States for Social Services'';

and

(C) by adding at the end the following:

''Subtitle B—Elder Justice

''SEC. 2011. DEFINITIONS.

''In this subtitle:

''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

''(2) ADULT PROTECTIVE SERVICES.—The term 'adult protective services' means such services provided to adults as the Secretary may specify and includes services such as—

''(A) receiving reports of adult abuse, neglect, or exploitation;

''(B) investigating the reports described in subparagraph (A);

''(C) case planning, monitoring, evaluation, and other case work and services; and

''(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

''(3) CAREGIVER.—The term 'caregiver' means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law,

and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

''(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.

''(5) ELDER.—The term 'elder' means an individual age 60 or older.

''(6) ELDER JUSTICE.—The term 'elder justice' means—

''(A) from a societal perspective, efforts to—

''(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

''(ii) protect elders with diminished capacity while maximizing their autonomy; and

''(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

''(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

''(8) EXPLOITATION.—The term 'exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

''(9) FIDUCIARY.—The term 'fiduciary'—

''(A) means a person or entity with the legal responsibility—

''(i) to make decisions on behalf of and for the benefit of another person; and

''(ii) to act in good faith and with fairness; and

''(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

''(10) GRANT.—The term 'grant' includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

''(11) GUARDIANSHIP.—The term 'guardianship' means—

''(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

''(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

''(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

''(12) INDIAN TRIBE.—

''(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

''(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

''(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

''(B) prosecutors;

''(C) medical examiners;

''(D) investigators; and

''(E) coroners.

''(14) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

''(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

''(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

''(16) NEGLECT.—The term 'neglect' means—

''(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

''(B) self-neglect.

''(17) NURSING FACILITY.—

''(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

''(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a skilled nursing facility (as defined in section 1819(a)).

''(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

''(A) obtaining essential food, clothing, shelter, and medical care;

''(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

''(C) managing one's own financial affairs.

''(19) SERIOUS BODILY INJURY.—

''(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

''(i) involving extreme physical pain;

''(ii) involving substantial risk of death;

''(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

''(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

''(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

''(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

''(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

''(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

''SEC. 2012. GENERAL PROVISIONS.

''(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

''(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

''(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

''(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

''(3) may be unambiguously deduced from the elder's life history.

''PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

''Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

''SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

''(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the 'Council').

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Council shall be composed of the following members:

''(A) The Secretary (or the Secretary's designee).

''(B) The Attorney General (or the Attorney General's designee).

''(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

''(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

''(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

''(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

''(f) DUTIES.—

''(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

''(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

''(A) describes the activities and accomplishments of, and challenges faced by—

''(i) the Council; and

''(ii) the entities represented on the Council; and

''(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

''(g) POWERS OF THE COUNCIL.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

''(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

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

''SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

''(a) ESTABLISHMENT.—There is established a board to be known as the 'Advisory Board on Elder Abuse, Neglect, and Exploitation' (in this section referred to as the 'Advisory Board') to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

''(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

''(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

''(d) TERMS.—

''(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

''(A) 9 shall be appointed for a term of 3 years;

''(B) 9 shall be appointed for a term of 2 years; and

''(C) 9 shall be appointed for a term of 1 year.

''(2) VACANCIES.—

''(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

''(f) DUTIES.—

''(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

''(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

''(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

''(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

''(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

''(A) information on the status of Federal, State, and local public and private elder justice activities;

''(B) recommendations (including recommended priorities) regarding—

''(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

''(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

''(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

''(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

''(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

''(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

''(g) POWERS OF THE ADVISORY BOARD.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

''(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

''(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

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

''SEC. 2023. RESEARCH PROTECTIONS.

''(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

''(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

''SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this subpart—

''(1) for fiscal year 2011, $6,500,000; and

''(2) for each of fiscal years 2012 through 2014, $7,000,000.

''Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

''SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

''(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

''(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

''(d) AUTHORIZED ACTIVITIES.—

''(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use

funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

''(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

''(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

''(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

''(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

''PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

''SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

''(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

''(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

''(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

''(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

''(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

''(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

''(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

''(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

''(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

''(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

''(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

''(ii) the establishment of motivational and thoughtful work organization practices;

''(iii) the creation of a workplace culture that respects and values caregivers and their needs;

''(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

''(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

''(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

''(5) DEFINITIONS.—In this subsection:

''(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(i) A long-term care facility.

''(ii) A community-based long-term care entity (as defined by the Secretary).

''(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

''(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

''(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making improvements to existing computer software and hardware.

''(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

''(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

''(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

''(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

''(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

''(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

''(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

''(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

''(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a

State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $20,000,000;

''(2) for fiscal year 2012, $17,500,000; and

''(3) for each of fiscal years 2013 and 2014, $15,000,000.

''SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

''(a) SECRETARIAL RESPONSIBILITIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

''(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

''(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

''(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

''(D) conducts research related to the provision of adult protective services; and

''(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

''(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

''(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

''(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

''(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

''(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

''(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

''(3) AUTHORIZED ACTIVITIES.—

''(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

''(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

''(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

''(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

''(c) STATE DEMONSTRATION PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

''(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

''(A) training modules developed for the purpose of detecting or preventing elder abuse;

''(B) methods to detect or prevent financial exploitation of elders;

''(C) methods to detect elder abuse;

''(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

''(E) other matters relating to the detection or prevention of elder abuse.

''(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

''SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

''(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

''(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

''(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

''(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

''(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

''(A) for fiscal year 2011, $5,000,000;

''(B) for fiscal year 2012, $7,500,000; and

''(C) for each of fiscal years 2013 and 2014, $10,000,000.

''(b) OMBUDSMAN TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

''SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

''(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

''(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

''(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

''(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

''(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

''(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

''(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

''(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

''(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

''(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

''(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

''(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

''(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether

the funding provided under the grant is expended only for the purposes for which it is made.

''(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

''SEC. 2045. REPORT.

''Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

''(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

''(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

''SEC. 2046. RULE OF CONSTRUCTION.

''Nothing in this subtitle shall be construed as—

''(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

''(2) creating a private cause of action for a violation of this subtitle.''.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

''(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

''(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

''(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section:

''REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

''SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

''(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

''(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

''(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

''(b) REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

''(2) TIMING.—If the events that cause the suspicion—

''(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

''(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

''(c) PENALTIES.—

''(1) IN GENERAL.—If a covered individual violates subsection (b)—

''(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

''(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

''(4) EXTENUATING CIRCUMSTANCES.—

''(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

''(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

''(i) areas or groups that are geographically isolated (such as isolated in a rural area);

''(ii) racial and ethnic minority populations; and

''(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

''(d) ADDITIONAL PENALTIES FOR RETALIATION.—

''(1) IN GENERAL.—A long-term care facility may not—

''(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

''(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

''(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

''(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

(i) who should be included in the registry;

(ii) how such a registry would comply with Federal and State privacy laws and regulations;

(iii) how data would be collected for the registry;

(iv) what entities and individuals would have access to the data collected;

(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;

(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report, Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Biologics Price Competition and Innovation Act of 2009''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that

are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(l) PATENTS.—

''(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

''(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

''(B) IN GENERAL.—

''(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

''(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

''(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

''(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

''(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

''(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

''(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

''(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

''(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

''(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

''(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

''(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

''(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

''(3) LIST AND DESCRIPTION OF PATENTS.—

''(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

''(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

''(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

''(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

''(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

''(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

''(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

''(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

''(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

''(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

''(4) PATENT RESOLUTION NEGOTIATIONS.—

''(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

''(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

''(5) PATENT RESOLUTION IF NO AGREEMENT.—

''(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

''(B) EXCHANGE OF PATENT LISTS.—

''(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

''(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

''(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

''(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

''(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

''(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

''(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

''(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

''(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

''(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

''(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

''(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

''(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

''(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

''(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

''(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

''(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

''(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

''(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

''(ii) not included, as applicable, on—

''(I) the list of patents described in paragraph (4); or

''(II) the lists of patents described in paragraph (5)(B).

''(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

''(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

''(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

''(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

''(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by adding ''or'' at the end; and

(iii) by inserting after subparagraph (B) the following:

''(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

''(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,''; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product'';

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking ''and'' at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

''(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

''(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

''(ii) for which an action for infringement of the patent with respect to the biological product—

''(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

''(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

''(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making,

using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

''(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.''.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: '', or section 351 of the Public Health Service Act''.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ''or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies''.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

''(n) NEW ACTIVE INGREDIENT.—

''(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

''(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.''.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking ''section 351'' and inserting ''subsection (a) or (k) of section 351''.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United State Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(m) PEDIATRIC STUDIES.—

''(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.''.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting '', biological products,'' after ''including drugs''.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

''(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

''(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

''(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.''.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 7003. SAVINGS.

(a) DETERMINATION.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle.

(b) USE.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 7101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

''(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

''(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.''.

(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears; and

(2) in subsection (b)—

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''; and

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

''(2) COVERED DRUG.—In this section, the term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.''.

(c) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding ''and'' at the end;

(B) in clause (ii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respectively; and

(B) by inserting after subparagraph (B), the following:

''(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—

''(i) IN GENERAL.—A hospital described in subparagraph (L), (M), (N), or (O) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

''(ii) INPATIENT DRUGS.—Clause (i) shall not apply to drugs purchased for inpatient use.

''(iii) EXCEPTIONS.—The Secretary shall establish reasonable exceptions to clause (i)—

''(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital's control;

''(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

''(III) to reduce in other ways the administrative burdens of managing both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

''(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.''.

(d) MEDICAID CREDITS ON INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by striking subsection (c) and inserting the following:

''(c) MEDICAID CREDIT.—Not later than 90 days after the date of filing of the hospital's most recently filed Medicare cost report, the hospital shall issue a credit as determined by the Secretary to the State Medicaid program for inpatient covered drugs provided to Medicaid recipients.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section and section 7102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) EFFECTIVENESS.—The amendments made by this section and section 7102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

''(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Performing spot checks of sales transactions by covered entities.

''(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

''(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

''(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

''(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

''(vi) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

''(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

''(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

''(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

''(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

''(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

''(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

''(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

''(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

''(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

''(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer's product have exceeded the applicable ceiling price under this section, and may submit such documents and information to the administrative official or body responsible for adjudicating such claim;

''(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings against a covered entity;

''(v) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

''(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

''(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: ''Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.''; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c),

by inserting ''after audit as described in subparagraph (D) and'' after ''finds,''.

SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ''340B program'') are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

TITLE VIII—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.

This title may be cited as the ''Community Living Assistance Services and Supports Act'' or the ''CLASS Act''.

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 4302(a), is amended by adding at the end the following:

''TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

''SEC. 3201. PURPOSE.

''The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

''(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

''(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

''(3) alleviate burdens on family caregivers; and

''(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

''SEC. 3202. DEFINITIONS.

''In this title:

''(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

''(2) ACTIVELY EMPLOYED.—The term 'actively employed' means an individual who—

''(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

''(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

''(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

''(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

''(6) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

''(i) has paid premiums for enrollment in such program for at least 60 months;

''(ii) has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

''(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

''(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

''(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

''(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms 'hospital', 'nursing facility', 'intermediate care facility for the mentally retarded', and 'institution for mental diseases' have the meanings given such terms for purposes of Medicaid.

''(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term 'CLASS Independence Advisory Council' or 'Council' means the Advisory Council established under section 3207 to advise the Secretary.

''(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term 'CLASS Independence Benefit Plan' means the benefit plan developed and designated by the Secretary in accordance with section 3203.

''(10) CLASS INDEPENDENCE FUND.—The term 'CLASS Independence Fund' or 'Fund' means the fund established under section 3206.

''(11) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(12) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(13) PROTECTION AND ADVOCACY SYSTEM.—The term 'Protection and Advocacy System' means the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15043).

''SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

''(a) PROCESS FOR DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

''(A) PREMIUMS.—

''(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, subject to clauses (ii) and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

''(ii) NOMINAL PREMIUM FOR POOREST INDIVIDUALS AND FULL-TIME STUDENTS.—

''(I) IN GENERAL.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

''(aa) any individual whose income does not exceed the poverty line; and

''(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

''(II) APPLICABLE DOLLAR AMOUNT.—The applicable dollar amount described in this subclause is the amount equal to $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year occurring after 2009 and before such year.

''(iii) CLASS INDEPENDENCE FUND RESERVES.—At such time as the CLASS program has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

''(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

''(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

''(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

''(ii) The individual requires substantial supervision to protect the individual from

threats to health and safety due to substantial cognitive impairment.

''(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

''(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

''(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

''(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

''(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

''(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

''(E) COORDINATION WITH SUPPLEMENTAL COVERAGE OBTAINED THROUGH THE EXCHANGE.—The benefits allow for coordination with any supplemental coverage purchased through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

''(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

''(A) evaluate the alternative benefit plans developed under paragraph (1); and

''(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

''(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

''(b) ADDITIONAL PREMIUM REQUIREMENTS.—

''(1) ADJUSTMENT OF PREMIUMS.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

''(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

''(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed).

''(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

''(I) has attained age 65;

''(II) has paid premiums for enrollment in the program for at least 20 years; and

''(III) is not actively employed.

''(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

''(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

''(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

''(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

''(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

''(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

''(E) PENALTY FOR REENROLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

''(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenollment is effective; or

''(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

''(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

''(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with subparagraphs (D) and (E) of paragraph (1)) shall be used to—

''(A) determine the monthly premium for enrollment in the CLASS program; or

''(B) prevent an individual from enrolling in the program.

''(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

''(1) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii), as part of their automatic enrollment in the CLASS program, to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed;

''(2) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

''(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

''SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

''(a) AUTOMATIC ENROLLMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

''(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

''(A) who is self-employed;

''(B) who has more than 1 employer; or

''(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

''(3) ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

''(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

''(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

''(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual—

''(1) who has attained age 18;

''(2) who—

''(A) receives wages on which there is imposed a tax under section 3201(a) of the Internal Revenue Code of 1986; or

''(B) derives self-employment income on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

''(3) who is actively employed; and

''(4) who is not—

''(A) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

''(B) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a

criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

''(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

''(e) PAYMENT.—

''(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

''(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

''(A) who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A); or

''(B) who does not earn wages or derive self-employment income.

''(f) TRANSFER OF PREMIUMS COLLECTED.—

''(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

''(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

''(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which—

''(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

''(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

''SEC. 3205. BENEFITS.

''(a) DETERMINATION OF ELIGIBILITY.—

''(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

''(2) ELIGIBILITY ASSESSMENTS.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

''(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

''(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

''(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

''(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

''(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

''(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

''(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

''(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

''(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

''(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

''(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

''(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

''(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

''(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

''(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

''(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advise and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(3).

''(c) PAYMENT OF BENEFITS.—

''(1) LIFE INDEPENDENCE ACCOUNT.—

''(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

''(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

''(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

''(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

''(ii) allowing the beneficiary to access such account through debit cards; and

''(iii) accounting for withdrawals by the beneficiary from such account.

''(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

''(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

''(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

''(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal

care services, habilitation services, and respite care under such a waiver or State plan amendment.

''(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

''(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

''(I) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act (42 U.S.C. 1396u–4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

''(2) AUTHORIZED REPRESENTATIVES.—

''(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

''(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

''(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

''(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

''(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

''(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

''(i) the total amount of the accrued deferred benefits; or

''(ii) the applicable annual benefit.

''(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

''(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

''(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

''(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

''(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

''(I) the death of a beneficiary; or

''(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

''(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

''(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

''(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

''(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

''(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

''(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

''(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

''(A) information regarding how to access the appeals process established for the program;

''(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

''(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

''(2) ensure that the System and such counselors comply with the requirements of subsection (h).

''(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

''(1) accessing and coordinating long-term services and supports in the most integrated setting;

''(2) possible eligibility for other benefits and services;

''(3) development of a service and support plan;

''(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

''(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

''(6) such other services as the Secretary, by regulation, may require.

''(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

''(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

''(h) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

''(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

''(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

''(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

''(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

''(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

''(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

''(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

''SEC. 3206. CLASS INDEPENDENCE FUND.

''(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

''(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

''(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

''(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

''(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act (42 U.S.C. 1395t).

''(c) BOARD OF TRUSTEES.—

''(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

''(2) DUTIES.—

''(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

''(i) Hold the CLASS Independence Fund.

''(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

''(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i).

''(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

''(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

''(i) include—

''(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

''(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

''(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

''(IV) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

''(ii) be printed as a House document of the session of the Congress to which the report is made.

''(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

''SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

''(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

''(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

''(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

''(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

''(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

''(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

''(1) the development of the CLASS Independence Benefit Plan under section 3203;

''(2) the determination of monthly premiums under such plan; and

''(3) the financial solvency of the program.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

''SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

''(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollees premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3202.

''(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan. For purposes of this subsection, the term 'taxpayer funds' means any Federal funds from a source other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings.

''(c) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

''(d) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

''(1) The total number of enrollees in the program.

''(2) The total number of eligible beneficiaries during the fiscal year.

''(3) The total amount of cash benefits provided during the fiscal year.

''(4) A description of instances of fraud or abuse identified during the fiscal year.

''(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or to prevent the occurrence of fraud or abuse.

''SEC. 3209. INSPECTOR GENERAL'S REPORT.

''The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

''(1) The eligibility determination process.

''(2) The provision of cash benefits.

''(3) Quality assurance and protection against waste, fraud, and abuse.

''(4) Recouping of unpaid and accrued benefits.

''SEC. 3210. TAX TREATMENT OF PROGRAM.

''The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.''.

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6505, is amended by inserting after paragraph (80) the following:

''(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and''.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (81) the following:

''(82) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

''(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

''(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

''(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.''.

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act and coverage available for purchase through a Exchange established under section 1311 of the Patient Protection and Affordable Care Act that is supplemental coverage to the benefits provided under a CLASS Independence Benefit Plan under that program, and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits.''; and

(2) in paragraph (3), by striking ''2010'' and inserting ''2015''.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) take effect on January 1, 2011.

(f) RULE OF CONSTRUCTION.—Nothing in this title or the amendments made by this title are intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

''SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

''(a) IMPOSITION OF TAX.—If—

''(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

''(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

''(b) EXCESS BENEFIT.—For purposes of this section—

''(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

''(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

''(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

''(B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

''(3) ANNUAL LIMITATION.—For purposes of this subsection—

''(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

''(B) APPLICABLE ANNUAL LIMITATION.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

''(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—

''(i) 2013.—In the case of 2013, the dollar limit under this subparagraph is—

''(I) in the case of an employee with self-only coverage, $8,500, and

''(II) in the case of an employee with coverage other than self-only coverage, $23,000.

''(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

''(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

''(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.

''(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

''(I) such amount as so in effect, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

''(D) TRANSITION RULE FOR STATES WITH HIGHEST COVERAGE COSTS.—

''(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

''(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

''(iii) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined using the most recent data available as of August 31, 2012.

''(c) LIABILITY TO PAY TAX.—

''(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

''(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

''(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the

same ratio to the amount of such excess benefit as—

''(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

''(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

''(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

''(A) IN GENERAL.—Each employer shall—

''(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

''(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

''(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

''(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

''(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

''(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

''(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

''(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or

''(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

''(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

''(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) DETERMINATION OF COST.—

''(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

''(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

''(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

''(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

''(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

''(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

''(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

''(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

''(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

''(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

''(2) LIMITATIONS ON PENALTY.—

''(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

''(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

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

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

''(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

''(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) COVERAGE DETERMINATIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

''(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

''(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—

''(A) is receiving coverage by reason of being a retiree,

''(B) has attained age 55, and

''(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

''(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

''(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

''(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

''(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

''(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.

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

''(8) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

''(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

''(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as

amended by section 1513, is amended by adding at the end the following new item:

''Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.''.

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

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W–2.

(a) IN GENERAL.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding after paragraph (13) the following new paragraph:

''(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

''(A) coverage to which paragraphs (11) and (12) apply, or

''(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAs.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) ARCHER MSAs.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''15 percent'' and inserting ''20 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

''(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''amounts in consideration for property,'' after ''wages,'',

(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and

(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(c)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

''(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

''(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

''(A) meets the community health needs assessment requirements described in paragraph (3),

''(B) meets the financial assistance policy requirements described in paragraph (4),

''(C) meets the requirements on charges described in paragraph (5), and

''(D) meets the billing and collection requirement described in paragraph (6).

''(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

''(A) IN GENERAL.—This subsection shall apply to—

''(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

''(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

''(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

''(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

''(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

''(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

''(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

''(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

''(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

''(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

''(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

''(ii) is made widely available to the public.

''(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

''(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

''(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

''(ii) the basis for calculating amounts charged to patients,

''(iii) the method for applying for financial assistance,

''(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

''(v) measures to widely publicize the policy within the community to be served by the organization.

''(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

''(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

''(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

''(B) prohibits the use of gross charges.

''(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

''(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).''.

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

''SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

''If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.''.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

''Sec. 4959. Taxes on failures by hospital organizations.''.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking ''and'' at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

''(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

''(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

''(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).''.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking ''and'' at the end of subparagraph (B), by inserting ''and'' at the end of subparagraph (C), and by adding at the end the following new subparagraph:

''(D) section 4959 (relating to taxes on failures by hospital organizations),''.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000	10 percent
More than $125,000,000 but not more than $225,000,000	40 percent
More than $225,000,000 but not more than $400,000,000	75 percent
More than $400,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''branded prescription drug sales'' means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term ''branded prescription drug'' means—

(i) any prescription drug the application for which was submitted under section 505(b)

of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term ''prescription drug'' means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term ''branded prescription drug sales'' shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term ''specified government program'' means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term ''Secretary'' includes the Secretary's delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any branded prescription drug sales after December 31, 2008.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting ''or section 9008(c) of the Patient Protection and Affordable Care Act of 2009'' after ''this part''.

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,000,000,000 as—

(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $25,000,000	50 percent
More than $25,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''medical device sales'' means sales for use in the United States of any medical device, other than the sales of a medical device that—

(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or

(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term ''medical device'' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(g) SECRETARY.—For purposes of this section, the term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity or to another entity by reason of the application of subsection (c)(2).

(i) APPLICATION OF SECTION.—This section shall apply to any medical device sales after December 31, 2008.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as—

(A) the sum of—

(i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus

(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any entity which provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks, or

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term ''United States health risk'' means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—For purposes of this section, the term ''third party administration agreement fees'' means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits

under an arrangement under which such employer self-insures the United States health risk of its employees.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk and third party administration agreement fees for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term ''health insurance'' shall not include insurance for long-term care or disability.

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk, and any third party administration agreement fees received after such date.

SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a study on the effect (if any) of the provisions of sections 9008, 9009, and 9010 on—

(1) the cost of medical care provided to veterans, and

(2) veterans' access to medical devices and branded prescription drugs.

(b) REPORT.—The Secretary of Veterans Affairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''7.5 percent'' and inserting ''10 percent''.

(b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year.''.

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''by substituting '10 percent' for '7.5 percent''' and inserting ''without regard to subsection (f) of such section''.

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

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

''(A) IN GENERAL.—No deduction shall be allowed under this chapter—

''(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

''(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—

''(I) the applicable individual remuneration for such disqualified taxable year, plus

''(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).

''(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

''(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'covered health insurance provider' means—

''(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

''(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

''(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

''(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

''(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term 'deferred deduction remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

''(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

''(i) who is an officer, director, or employee in such taxable year, or

''(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

''(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

''(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''In addition'' and inserting the following:

''(1) IN GENERAL.—In addition'',

(B) by striking ''the following percentages of the'' and inserting ''1.45 percent of the'',

(C) by striking ''(as defined in section 3121(b))—'' and all that follows and inserting ''(as defined in section 3121(b)).'', and

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

''(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

''(A) in the case of a joint return, $250,000, and

''(B) in any other case, $200,000.''.

(2) COLLECTION OF TAX.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULES FOR ADDITIONAL TAX.—

''(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

''(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

''(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.''.

(b) SECA.—

(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''In addition'' and inserting the following:

''(1) IN GENERAL.—In addition'', and

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

''(2) ADDITIONAL TAX.—

''(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.5 percent of the self-employment income for such taxable year which is in excess of—

''(i) in the case of a joint return, $250,000, and

''(ii) in any other case, $200,000.

''(B) COORDINATION WITH FICA.—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.''.

(2) NO DEDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting ''(other than the taxes imposed by section 1401(b)(2))'' after ''section 1401)''.

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting ''(determined without regard to the rate imposed under paragraph (2) of section 1401(b))'' after ''for such year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

''CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES

''SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

''(a) IN GENERAL.—There is hereby imposed on any cosmetic surgery and medical procedure a tax equal to 5 percent of the amount paid for such procedure (determined without regard to this section), whether paid by insurance or otherwise.

''(b) COSMETIC SURGERY AND MEDICAL PROCEDURE.—For purposes of this section, the term 'cosmetic surgery and medical procedure' means any cosmetic surgery (as defined in section 213(d)(9)(B)) or other similar procedure which—

''(1) is performed by a licensed medical professional, and

''(2) is not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

''(c) PAYMENT OF TAX.—

''(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the procedure is performed.

''(2) COLLECTION.—Every person receiving a payment for procedures on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the procedure is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

''(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for cosmetic surgery and medical procedures are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the procedure.''.

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

''CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to procedures performed on or after January 1, 2010.

Subtitle B—Other Provisions

SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

''SEC. 139D. INDIAN HEALTH CARE BENEFITS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.

''(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—

''(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

''(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

''(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and

''(4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the Federal government to Indian tribes or members of such a tribe.

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term by section 45A(c)(6).

''(2) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.

''(3) MEDICAL CARE.—The term 'medical care' has the same meaning as when used in section 213.

''(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in section 105.

''(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

''(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a) shall not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of this chapter, or to the amount of any such benefit for which a deduction is allowed to such beneficiary under any other provision of this chapter.''.

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Indian health care benefits.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans), as amended by this Act, is

amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (i) the following new subsection:

''(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

''(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

''(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

''(A) which is established and maintained by an eligible employer, and

''(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

''(3) CONTRIBUTION REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

''(i) a uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or

''(ii) an amount which is not less than the lesser of—

''(I) 6 percent of the employee's compensation for the plan year, or

''(II) twice the amount of the salary reduction contributions of each qualified employee.

''(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

''(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

''(D) DEFINITIONS.—For purposes of this paragraph—

''(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

''(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

''(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).

''(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416(i).

''(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

''(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

''(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

''(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

''(i) who have not attained the age of 21 before the close of a plan year,

''(ii) who have less than 1 year of service with the employer as of any day during the plan year,

''(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

''(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

''(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

''(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

''(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

''(i) IN GENERAL.—If—

''(I) an employer was an eligible employer for any year (a 'qualified year'), and

''(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

''(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

''(D) SPECIAL RULES.—

''(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

''(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

''(7) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010.

SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

''SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

''(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

''(b) QUALIFIED INVESTMENT.—

''(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project.

''(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.

''(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—

''(A) for remuneration for an employee described in section 162(m)(3),

''(B) for interest expenses,

''(C) for facility maintenance expenses,

''(D) which is identified as a service cost under section 1.263A-1(e)(4) of title 26, Code of Federal Regulations, or

''(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

''(4) CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

''(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

''(c) DEFINITIONS.—

''(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

''(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

''(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

''(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

''(2) ELIGIBLE TAXPAYER.—

''(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

''(B) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection

(m) or (o) of section 414, shall be so treated for purposes of this paragraph.

''(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—

''(A) mortgage or rent payments,

''(B) insurance payments,

''(C) utility and maintenance costs, and

''(D) costs of employment of maintenance personnel.

''(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

''(B) LIMITATION.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

''(2) CERTIFICATION.—

''(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

''(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

''(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

''(3) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

''(A) shall take into consideration only those projects that show reasonable potential—

''(i) to result in new therapies—

''(I) to treat areas of unmet medical need, or

''(II) to prevent, detect, or treat chronic or acute diseases and conditions,

''(ii) to reduce long-term health care costs in the United States, or

''(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

''(B) shall take into consideration which projects have the greatest potential—

''(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

''(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

''(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

''(e) SPECIAL RULES.—

''(1) BASIS ADJUSTMENT.—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

''(2) DENIAL OF DOUBLE BENEFIT.—

''(A) BONUS DEPRECIATION.—A credit shall not be allowed under this section for any investment for which bonus depreciation is allowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).

''(B) DEDUCTIONS.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which is reduced under paragraph (1), or which are described in section 280C(g).

''(C) CREDIT FOR RESEARCH ACTIVITIES.—

''(i) IN GENERAL.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

''(ii) EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.—Any expenses for any taxable year which are qualified research expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.

''(f) COORDINATION WITH DEPARTMENT OF TREASURY GRANTS.—In the case of any investment with respect to which the Secretary makes a grant under section 9023(e) of the Patient Protection and Affordable Care Act of 2009—

''(1) DENIAL OF CREDIT.—No credit shall be determined under this section with respect to such investment for the taxable year in which such grant is made or any subsequent taxable year.

''(2) RECAPTURE OF CREDITS FOR PROGRESS EXPENDITURES MADE BEFORE GRANT.—If a credit was determined under this section with respect to such investment for any taxable year ending before such grant is made—

''(A) the tax imposed under subtitle A on the taxpayer for the taxable year in which such grant is made shall be increased by so much of such credit as was allowed under section 38,

''(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and

''(C) the amount of such grant shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.

''(3) TREATMENT OF GRANTS.—Any such grant shall not be includible in the gross income of the taxpayer.''.

(b) INCLUSION AS PART OF INVESTMENT CREDIT.—Section 46 of the Internal Revenue Code of 1986 is amended—

(1) by adding a comma at the end of paragraph (2),

(2) by striking the period at the end of paragraph (5) and inserting '', and'', and

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

''(6) the qualifying therapeutic discovery project credit.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 49(a)(1)(C) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''and'' at the end of clause (iv),

(B) by striking the period at the end of clause (v) and inserting '', and'', and

(C) by adding at the end the following new clause:

''(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.''.

(2) Section 280C of such Code is amended by adding at the end the following new subsection:

''(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

''(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or section 45C were allowed with respect to such expenses for such taxable year, and

''(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

''(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and

''(ii) the amount of any basis reduction under section 48D(e)(1).

''(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—In the case of expenses described in paragraph (1)(A) taken into account in determining the credit under section 48D for the taxable year, if—

''(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds

''(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

''(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

''Sec. 48D. Qualifying therapeutic discovery project credit.''.

(e) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the amount of 50 percent of such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(2) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(d)(2) of the Internal Revenue Code of 1986 for a credit under such section for the taxable year of the applicant which begins in 2009 shall be considered to be an application for a grant under paragraph (1) for such taxable year.

(B) TAXABLE YEARS BEGINNING IN 2010.—An application for a grant under paragraph (1) for a taxable year beginning in 2010 shall be submitted—

(i) not earlier than the day after the last day of such taxable year, and

(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.

(C) INFORMATION TO BE SUBMITTED.—An application for a grant under paragraph (1) shall include such information and be in

such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year for the qualified investment with respect to which such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant, or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of an ongoing nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term ''qualified investment'' means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in tax under chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the grant was made.

(B) SPECIAL RULES.—

(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable as a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under paragraph (1), the identity of the person to whom such grant was made, or a description of the investment with respect to which such grant was made be treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—

(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),

(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,

(C) any entity referred to in paragraph (4) of section 54(j) of such Code, or

(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).

In the case of a partnership or other pass-thru entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partnership or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.

(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

(9) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 46(6) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for which a grant is awarded under this subsection.

(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

(11) TERMINATION.—The Secretary of the Treasury shall not make any grant to any person under this subsection unless the application of such person for such grant is received before January 1, 2013.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Senate Committee on Energy and Natural Resources. The hearing will be held on Thursday, December 3, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on H.R. 3276, the American Medical Isotopes Production Act of 2009.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie__Calabro @energy.senate.gov

For further information, please contact Jonathan Epstein at (202) 224–3357 or Rosemarie Calabro at (202) 224–5039.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on November 19, 2009, in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session to conduct a hearing on November 19, 2009, at 10:30 a.m., in room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, to conduct a hearing entitled ''Hearing on Nominations for Commissioner and for General Counsel of the Equal Employment Opportunity Commission'' on November 19, 2009. The hearing will commence at 10 a.m. in room 430 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. to conduct a hearing entitled ''The Fort Hood Attack: A Preliminary Assessment.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:15 p.m. in Room 628 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on November 19, 2009, at 10 a.m. in SD–226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. AKAKA. Mr. President, I ask unanimous consent that Dr. Andrea Buck, a physician detailed to the Veterans' Affairs Committee staff from the VA Inspector General's Office be granted the privilege of the floor for the duration of the debate on S. 1963.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. Mr. President, I ask unanimous consent that Rachel Pelham of my staff be given the privilege of the floor for the rest of the day.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent for Randoe Dice, a detailee on my staff, Ben Bremen, Anne Pick, and Joseph Moon, interns on my staff, be granted the privileges of the floor during debate of H.R. 3590.

The PRESIDING OFFICER. Without objection, it is so ordered.

IRAN'S HUMAN RIGHTS VIOLATIONS

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 355, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 355) expressing the sense of the Senate that the Government of the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law.

There being no objection, the Senate proceeded to consider the resolution.

Mr. LEVIN. Mr. President, recent events have made abundantly clear that the Government of the Islamic Republic of Iran is failing, and failing badly, to live up to its own professed ideals and its international commitments to protect the human rights of its citizens and others. I urge my colleagues to join with me in supporting a resolution, S. Res. 355, submitted today, condemning Iran's deplorable human rights record, calling for an immediate release of those wrongfully imprisoned in violation of their rights, and urging the restoration of meaningful human rights to all of Iran's citizens.

Iran's 1979 constitution, the result of a revolution against years of political and human-rights abuses by the regime of the Shah, guarantees fundamental rights and freedoms. Moreover, Iran is a signatory to four major human rights treaties. And yet its shameful record of executions that contravene international standards; of repression of the rights of women and minorities, including religious minorities; of outrageous attacks on the rights of peaceful assembly and protest; and of unwarranted arrest and detention of foreigners, including Americans, all make a mockery of these commitments.

Just last week, the Iranian Government again demonstrated its contempt for human rights and the rule of law when it announced it would pursue espionage charges against three young Americans who crossed Iran's border with Iraq. These allegations are just the latest telling example on a long list of abuses.

American Robert Levinson has been missing in Iran for more than two years, during which the Iranian regime has denied having any information on his whereabouts and has blocked international attempts to discover his fate. In January 2009, the Iranian Government jailed Iranian-American journalist Roxana Saberi and charged and convicted her of espionage after a one-hour show trial that mocked even the most basic standards of due process and law, and then sentenced her to eight years in prison before releasing her a few months later. Esha Momeni, a student at California State University, Northridge, was imprisoned last fall for her peaceful activities in support of women's rights in Iran. The regime's abuses have even touched Nobel peace prize winner Shrin Ebadi, whose Center for Defenders of Human Rights was forced to close by the government in December 2008.

None of these recent abuses, however, as deplorable as they are, have shocked the conscience of the world so severely as the Iranian Government's actions in response to this year's disputed presidential elections. Prompted by justifiable concern that their will had been thwarted in a rigged election, thousands of Iranian citizens took to the streets, firmly but peacefully exercising their rights and demanding the democracy their government purports to embody. The regime's response was to launch violent, heavy-handed attacks against these peaceful protestors, using government security forces and paramilitary militias under government control to repress the legitimate expression of a valid grievance. The United Nations High Commissioner for Human Rights reports that this violence resulted in at least a dozen deaths, and hundreds of injuries.

In the aftermath, the Iranian Government imprisoned dozens of its citizens and conducted a mass trial of more 100 of them, many of whom bore clear signs of physical abuse. The government sentenced at least four of these prisoners to death on the basis of dubious confessions, likely produced under duress and abuse.

It is proper and appropriate for the Senate to make clear its determination that these acts violate international human rights standards, Iran's own professed commitments, and common decency. The resolution introduced today would record the Senate's condemnation of Iran's woeful human rights record; remind the Iranian government of its domestic and international commitments to human rights; call for the immediate release of all those held for their peaceful exercise of rights of free expression, assembly and association; and urge Iran to extend full legal rights to those imprisoned. It calls for the Iranian Government to guarantee humane treatment of those in detention; to halt immediately state-sanctioned violence against its own citizens; to allow unrestricted communication and access to information; and to respect the rights of the Iranian people to free speech, a free press, free expression of religion, freedom of association, and freedom of assembly.

It is a tragic irony that the government perpetrating these deplorable acts of violence and abuse came to power three decades ago because the Iranian people rejected the abuses and violence of a previous regime. Now following in the repressive footsteps of that previous regime, the current Iranian Government has been widely condemned by the community of nations. Passage of this resolution would add the U.S. Senate's loud and clear voice of condemnation to the many voices inside Iran, and out, calling for the restoration of basic human rights for the Iranian people.

Mr. KAUFMAN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table en bloc; that any statements relating to the resolution be printed in the RECORD without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 355) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 355

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the

Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which its ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women's rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary arrest, indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one's faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja'far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year-old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran jailed Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women's rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Nations High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Iranian Journalists in August 2009, the country's largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used brutal force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations;

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including artists and filmmakers since the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani, human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning: Now, therefore, be it

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(2) condemns the Government of Iran's human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory;

(4) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhumane, or degrading treatment;

(6) calls for the Government of Iran to ensure those currently in detention are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the ''freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in print, in the form of art, or through any other media of his choice''.

ORDER FOR PRINTING OF AMENDMENT NO. 2786

Mr. KAUFMAN. I ask unanimous consent that amendment No. 2786 be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, and in consultation with the ranking member of the Senate Committee on Finance, pursuant to Public Law 103–296, appoints Jagadeesh Gokhale, of Maryland, vice Sylvester Schieber, of Michigan, as a member of the Social Security Advisory Board.

ORDERS FOR FRIDAY, NOVEMBER 20, 2009

Mr. KAUFMAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m. tomorrow, Friday, November 20; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume debate on the motion to proceed to H.R. 3590, as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. KAUFMAN. Mr. President, there will be no rollcall votes during tomorrow's session of the Senate. The next vote will occur at 8 p.m. on Saturday, November 21. That vote will be on the motion to invoke cloture on the motion to proceed to H.R. 3590.

ORDER FOR ADJOURNMENT

Mr. KAUFMAN. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators BROWNBACK and HATCH.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Utah.

Mr. HATCH. Mr. President, I thank my colleague.

HEALTH CARE REFORM

Mr. HATCH. Mr. President, I would like to take my time to talk about the critical issue of health care reform as this body stands at a historic crossroad on this national challenge.

We have never seen anything like the issues facing our country right now. The line between private businesses and public government has never been so blurred. Just look at this chart I have in the Chamber. Government effectively owns several of our Nation's institutions: insurance companies, financial institutions, banks and automobile manufacturers. CEOs have been fired by government bureaucrats, and Washington is now in the business of dictating salaries in the private sector. With government takeovers on the rise, drastic labor law changes being pushed forward, and sweeping new corporate taxes circling overhead, we are truly moving toward a European-style government at a time when most European countries are moving away from it.

I deliver these remarks with a heavy heart because what could have been a strong, bipartisan bill reflecting our collective and genuine desire for responsible health care reform on one-sixth of the American economy continues to be an extremely partisan exercise, pushing for more Federal spending, bigger government, and higher taxes as a flawed solution.

At the outset, let me make one point as clearly as possible. We are all for reform, everybody on this floor. Every Republican colleague whom I have talked to wants to reform our current health care system. Ensuring access to affordable and quality health care for every American is not a Republican nor is it a Democrat issue or idea; it is an American issue. Our Nation expects us to solve this challenge in an open, honest, and responsible manner.

Clearly, health care spending continues to grow too fast. This year will mark the largest ever 1-year jump in the health care share of our GDP—a full percentage point, to 17.6 percent. Growing health care costs translate directly into higher coverage costs.

Since the last decade, the cost of health coverage has increased by 120 percent—three times the growth of inflation and four times the growth of wages. Rising costs is the primary driver behind why we continue to see a rising number of uninsured in our country and why an increasing number of businesses find it hard to compete in a global market. Without addressing this central problem, we cannot have a real and sustainable health care reform bill.

Unfortunately, the Senate health bill, according to the nonpartisan Congressional Budget Office, will actually increase Federal spending by $160 billion in the next 10 years instead of lowering it. Mr. President, you heard me right: It will increase spending.

After the rushed stimulus bill, Americans are rightly concerned about what is being pushed through this Democratic Congress. The rush to pass something that will affect every American life and business has raised concerns all around our Nation. In a recent Gallup Poll, a majority of Americans believed their health care costs could actually get worse under the Democratic health care plans. So why are Americans so skeptical and concerned? Because they are being promised the impossible. They are being told that this trillion-dollar addition of taxpayer dollars to our health care system will actually preserve their current benefits, not raise their taxes, and it will reduce the Federal deficit. Even David Copperfield would be hard pressed to pull off this trick.

Many Americans recently had a first-hand encounter with the efficiency of the Federal Government in administering the H1N1 vaccination around the country. Their experience consisted of standing in long lines for several hours in sterile government buildings, only to be told they were suddenly out of doses.

Republicans in Congress agree with the majority of Americans who believe that just throwing more hard-earned taxpayer dollars at a problem will not deliver meaningful reform. Simply telling the American people that the solution for solving a $2 trillion health care system is to simply spend another $2.5 trillion just does not make sense.

With nearly a half trillion dollars in new taxes, this big stack of papers is a textbook example of the liberal tax-and-spend philosophy. Now compare that with the Constitution of the United States. This little booklet contains the whole Constitution of the United States. Yet we have a health care bill that is 2,024 pages long. Come on. That is an example of the liberal tax-and-spend philosophy we see around here.

Here are some of the highlights of this piece—this piece of equipment, this bill, this massive, massive bill; I can hardly lift the darn thing—$28 billion in new taxes on employers through a mandate that will disproportionately affect low-income Americans, and all at a time when our unemployment rate stands at an unacceptable 10.2 percent; $8 billion in new taxes on Americans who fail to buy a Washington-defined level of health care coverage; $372 billion in new taxes on everything from insurance premiums, to prescription drugs, to hearing devices and wheelchairs—all of which are going to be passed on to the consumers, most all of whom are earning less than $200,000 a year. As I said, there is no such thing as a free lunch, especially when Washington is inviting you over.

Representatives from both the Congressional Budget Office, CBO, and the Joint Committee on Taxation, JCT, have testified before the Finance Committee that these taxes will be passed on to the consumers. That is you and me. That is you and me and every other constituent in this country. So even though the bill tries to hide these costs as indirect taxes, average Americans who purchase health plans, use prescription drugs, and buy medical devices—everything from hearing aids to crutches—will end up footing the bill.

By the way, we all know when this bill is fully implemented it will cost significantly more. Every time Washington tells you something will cost $1, you can count on it costing $10. History is prologue. Medicare started off with a $65 million—that is with an ''m''—a year budget and now it has a $400 billion budget. So look for these taxes only to go up in the future, as we have just given the Federal Government a whole new checkbook, if we pass this bill.

Let me also talk a little bit about the myth of this health care reform proposal actually reducing the deficit. Here is the harsh reality: The Congressional Budget Office recently reported that our national deficit for fiscal year 2009 alone was a shocking $1.4 trillion.

Let me put this in perspective. We have exploding deficits. In 2008, it was $459 billion—the last year of the Bush administration. In the first year of the Obama administration, it is $1.4 trillion. It is more than three times our deficit from last year and almost 10 percent of the entire economy. This is the largest yearly deficit since 1945. This should send shivers down the spine of every American out there. We are literally drowning this Nation and the future of this Nation in a sea of red ink.

The biggest bait-and-switch on the American people about the bill's impact on the deficit is a simple math trick. If something is expensive to do for a full 10-year period, just do it for 5 years and call it 10 years. Most of the major spending provisions of the bill do not go into effect until 2014 or even later—coincidentally, after the 2012 Presidential elections. So what we are seeing is not a full 10-year score but, rather, a 5- to 6-year score.

Now chart 3: This is the real cost of the Senate plan. The CBO score—because it only scores, really, basically 5 or 6 years because major provisions of the bill are not implemented until 2014, in some respects up to 2015—they claim, is only $849 billion, or less than $1 trillion. But the full 10-year score, according to the Senate Budget Committee, fully implemented, if you do it for 10 years, is $2.5 trillion. The House bill is even at a more astonishing level of $3 trillion.

Let me go to chart 4, because in our current fiscal environment, where the government will have to borrow nearly 43 cents of every $1 it spends this year, let's think hard about what we are doing to our country and our future generations.

For months, I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraints while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the

basis for a sustainable, fiscally responsible, and bipartisan reform. These include reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition; protecting the coverage for almost 85 percent of Americans who already have coverage they like by making it more affordable—this means reducing costs by rewarding quality and coordinated care, by giving families more information on the cost and choices of their coverage and treatment options, by discouraging frivolous lawsuits, and by promoting prevention and wellness measures.

We should give States flexibility to design their own unique approaches to health care reform in accordance with their own demographics. Utah is not New York and New York is not Utah. Actually, what works in New York will most likely not work in New York, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics and each State has developed its own institutions to address its challenges. And each has its own successes.

There is an enormous reservoir of expertise, experience, and field-tested reform out there. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and challenges. We should utilize the principle of federalism by having 50 State laboratories where we can look at the other States and see what works and what does not. Utah is a State where we have a tremendous health care system. It is rated one of the top three in this Nation. Wouldn't other States be benefited by looking at the Utah system, or Minnesota? The Minnesota system is a very good system, according to what they tell me. We could learn from them. You could learn from all 50 States what to do and what not to do. Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce a defined contribution health benefits system and implement the Utah Health Exchange are laudable accomplishments.

Just like you, I strongly believe a one-size-fits-all Washington solution is not the right approach. We should empower small businesses and self-employed entrepreneurs—the job-creating engines and lifeblood of our economy—to buy affordable coverage by giving them the same purchasing advantages as the large companies.

Unfortunately, the path we are taking in Washington right now is simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. Republicans want to sit down and write a bill together to achieve sustainable reform that we can all afford. We do not believe in the ''our way or the highway'' approach on an issue that will affect every American life and every American business.

Republicans have put forth ideas, both comprehensive and incremental, through this health care reform debate, especially during committee considerations.

These ideas were either summarily rejected on party line votes or simply stripped out in the dark of the night before the final version was released. And this version is no exception. This version was done in the back rooms of the Capitol with the White House and very few Senators cobbling together what they thought would be a compromise between the HELP bill and the Finance Committee bill, and maybe even with some consideration to the House bill. There was no real bipartisan work on this bill. There was no real attempt to try and bring people together. It was strictly a partisan bill, as have been the HELP Committee bill, primarily the Finance Committee bill, and above all, the House bill.

I am especially disappointed that the President and the Democratic leadership in the House and the Senate have chosen to pursue the creation of a new government-run plan—one of the most divisive issues in health care reform—rather than focusing on broad areas of compromise that can lead us toward bipartisan health care reform legislation. At a time when major government programs such as Medicare and Medicaid are already on a path to fiscal insolvency, creating a brandnew government program will only worsen our long term financial outlook. To put this in perspective, as of this year, Medicare has a liability of almost $38 trillion, which, in turn, translates into a financial burden of more than $300,000 per American family over time.

So what is the Washington solution to address this crisis? We will take up to $500 billion out of this bankrupt program and use it to expand another bankrupt program—Medicaid—and create a brandnew Washington-run plan, a Washington government-run plan. I am not an economist, but I know that taking money out of one bankrupt program to create another is not a good idea. We should be reforming Medicare and Medicaid for our people, but instead we keep spending, and to take $500 billion out of Medicare which has a $38 trillion unfunded liability to create another government run program I think is immoral. It is certainly not very economically sound. I could keep going, but the point here is simple: Washington is not the answer.

The impact of a new government program on families who currently have private insurance of their choice is also alarming. A recent study estimated that cost shifting from government payers already costs families with private insurance nearly $1,800 more per year. This is nothing more than another hidden government tax. Do you all get that? Because Medicare pays doctors 20 percent less and pays hospitals 30 percent less, and other providers even less, those who have private health insurance have to pick up the cost, and it averages $1,800 per family. Think about that. That is because government has been running those programs. Creating another government plan will further increase these costs on our families in Utah and across this country.

Let me take a couple of minutes to talk about process. The Democratic leadership spent almost—well, they took 6 weeks behind closed doors to write this bill. It is only fair to expect that we will at least have 72 hours to review these—I said 2,024 but it is 2,074—pages. This thing right here. This is the bill. My gosh, 2,074 pages. Tolstoy's ''War and Peace'' was about a little more than 1400 pages. This is a bill—we ought to have at least 72 hours to review these 2,074 pages before beginning any Senate floor action.

We are going to vote on Saturday at 8 o'clock on whether we should proceed, but it won't be proceeding to this bill, it is going to be proceeding to a shell bill. If they are able to proceed, then they will bring up a substitute bill which will be the bill they have worked on for 6 weeks in closed rooms. It will be a shell bill that will get it going. It is a shell game, between you and me, one that is done right here in Washington by people who believe the Federal Government is the last answer to everything.

As a bill that affects every American life and every American business, 2,074 pages is too big and it is too important not to have full public review. In fact, I think 72 hours is not enough. We need a lot more time. We are talking about one-sixth of the American economy.

To enact true health care reform, we have to come together as one to write a responsible bill for the American families who are faced with rising unemployment and out-of-control health care costs.

Our national debt is ready to double in the next 5 years. Look at that. The red lines are the projected national debt under the current administration. That debt is projected to double in the next 5 years and triple in the next 10 years. Let me tell you who catches onto this. It is our friends over in China to whom we owe $800 billion. Think about it. They are concerned about the devaluation of the American dollar because they see us being profligate here in Washington.

Let's slow down and think about what we are doing to our future generations. I think there is still time to press the reset button and write a bill together that every one of us can support and be proud of. Right now, Republicans aren't just standing in the way. We actually believe we can do a bipartisan bill if we had a chance, if we had a real, good faith effort by both sides. The HELP Committee bill wasn't done that way. We did have a markup in the HELP Committee and almost every substantive amendment was voted down on a party line vote. The same thing basically happened in the Finance Committee, although I have to

say that the distinguished Senator from Montana, the chairman of the Finance Committee, made every effort to try and bring people together. I give him a lot of credit for it. But he was so severely restricted by his side that there was no way people could support it. I was a member of the Gang of 7, but I began to realize what the final bill was going to be. I couldn't support it, so I thought the honorable thing to do, instead of coming out of every one of our meetings and finding fault with what they were talking about, was to leave the Gang of 7, and I did that. I felt bad doing it because I wanted to help work on a bipartisan bill. But the distinguished chairman was so restricted by his side that there was no way we could have a bipartisan bill out of that committee. It is disappointing to me, as somebody who has worked on so many health care matters over the years—everything from Hatch-Waxman to the orphan drug bill to the CHIP bill—you can name it—that we didn't have the guts or the ability to sit down and work this thing out together.

Now we are going to get sold a bill of goods here that doesn't make sense. This is a travesty. It is a travesty. It is hard to believe they think they can pawn this off on the American people. My gosh. I know some of the folks who have done this are well intentioned, but not for this stuff. I was going to say something else, but I want to be very kind here.

The Constitution—this is the whole Constitution, the most important document, political document in the history of the world. Plus it has a lot of interesting material in the back, plus an index and so forth, but that is it, right there. Here is what one-sixth of the American economy is going to be if we allow it to go forward. I personally believe we ought to kill this bill and then we ought to sit down and work it out together. If there were a real bona fide attempt to do that, I have no doubt we could do it. We have done it in the past.

One of the things I found most disappointing is that the polls show that 85 percent of the people who have insurance are relatively happy with it. Yes, they would like premiums to go down, they would like to be able to have it be even better, but they are basically happy with their health care coverage. If you deduct the 6 million people who work for businesses that provide health insurance but they don't take it—they would rather have the money—and you deduct the 11 million people who qualify for CHIP, the child health care program, which is a Hatch-Kennedy bill, by the way; or they qualified for Medicaid—if you deduct those 11 million people, and then you deduct the 9 million people who earn over $75,000 a year and can afford their own health insurance, and then you take away the illegal aliens, it comes down to 7 million to 12 million people who need health insurance. Think about that. We are going to throw out the whole system of health care that 85 percent of the people basically believe is worthwhile over, 7 to 12 million people whom we could help in a way that would be reasonable; and we are going to change our health care system from State-run systems and bring it right here to Washington where a bunch of Federal bureaucrats who are far removed from people in the States will determine every aspect of health care in our lives, and run our health care system into the ground even further, as they have Medicare and Medicaid, without the appropriate reforms that would keep those programs that could be great programs and are great programs in some ways, going. They will say, well, aren't those government programs? Yes, they are government programs, and they are both deeply in debt. Medicare goes into insolvency by 2017. Medicaid is also going bankrupt. What are we going to do, saddle our young people for the rest of their lives with untold expenses? We are going to saddle them with this huge stack of paper? My gosh. No wonder we are in such deep financial difficulties in this country.

If we are going to rely on the Federal Government to solve our problems, we are making the most tragic mistake we possibly can. The Federal Government could participate, but let me tell you, if we work on a bipartisan bill—let me make one last point. If you have a bill that affects one-sixth of the American economy—and whatever passes here, if it does, will be a bill that will be concerned with one-sixth of our American economy—if you have a bill that is that important and you can't get 75 or 80 votes in the Senate, you know that is a lousy bill, and you know it is a partisan bill, and you know it hasn't been well thought out, and you know it is one sided, and you know it is going to cause an uproar throughout this country that has never been seen before—it already is—and you know it won't work, yet we are going to saddle this country with this monstrosity. I have to tell you, I can hardly believe it. I can hardly lift it. I am not exactly weak. All I can say is that it is a huge monstrosity.

Think of the Constitution. There is the whole Constitution right there, yet we have a health care bill this big. I am concerned about it, as you can see, and I am worked up about it, because there are some of us who would like to work together and do a bipartisan bill, but we have to be honest about it, there hasn't been any chance to do it. This bill in particular has been worked on in the back rooms between the White House and very few Senators, and without any input from our side at all, frankly, ignoring many of the good things that have been expressed on our side.

I hope we will think this through and I hope we won't pass this. I hope we can then sit down and do a bill that will work, that will not burden our future generations.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I am glad to follow my colleague from Utah. I have great admiration and affection for him. He has done a lot of good, bipartisan legislation. I hope my colleagues will heed his word. He is good to his word, and he would be willing to do a bipartisan bill.

On top of that, if the Democratic leadership would back up and do a bipartisan bill, the American people would cheer. They would think this was extraordinary, and we could get something substantive done and not this monster.

I am ranking member of the Joint Economic Committee, and we had Secretary Geithner in to testify today. I disagree with a number of things he has done. He is a bright and energetic man with a lot of experience. I noted to him—and he knows this is the case—that we are $12 trillion in the hole. We are hemorrhaging money at the Federal level. Why on Earth we would do the fiscally insane thing of adding a multitrillion dollar entitlement program, when we are $12 trillion in the hole and hemorrhaging Federal money, and you have the President just back from seeing the bankers in China, who have nearly a trillion dollars of our debt? As a Senator and as an American, I don't like that we are dependent upon the Chinese for that much money. I don't think the American people like that. Why on Earth would we do this? He said that people are mad out there. We talked ahead of time, and he said that people are upset across the country. I said, yes, they are, and it is because of this. They are mad and they are scared. Neither of those is a situation where you ought to try to force something through on people who are mad and scared about it. They are mad about things being rammed through, and they are scared about the level of debt and deficit, and they are adding this scale of entitlement on top of an already broken fiscal situation.

The rest of the world is yelling at the United States to get your fiscal house in order, and we are going to add a multitrillion dollar entitlement program, when we all know we ought to get our fiscal house in order. Then the way it is paid for is to raise taxes $½ trillion in a weak economy. That is going to hurt the economic expansion and job creation we need. Then you are supposedly going to save $400 billion out of Medicare, which I noted to him. That song has been tried in the past. We had these fixes that we were going to reduce payments to providers, to the physician community. For 4 years now in a row we have changed and said we were going to do this provider cut—a minor provider cut—and then Congress said that is too much, we are not going to do that. We will fill that back up. For three or four of those, I have voted for that.

Then there is the idea that we are going to cut $400 billion out of Medicare, which is already on a fiscally irresponsible track and going broke. We are going to take $400 billion out of that. That is not going to happen. If it did happen, it would wreck Medicare. This is a bad idea at a bad time. We should not do this. We should not do it this way.

I want to focus more of my comments on a narrower piece of this, which has gotten a lot of focus in the House and should get focus in the Senate. It is the radical expansion of Federal funding of abortions that is in this bill. Let's put it on its bottom line. They should put the Stupak language in the Senate bill, and instead the Capps language is in the bill. The Capps language will expand Federal financing of abortion—Federal taxpayer funding of abortion. The Stupak language is something we have supported here for 30 years. It is the Hyde language—the language that 64 Democrats voted for in the House. Instead, in this bill you have Federal taxpayer funding of abortions, something we have not done for 30 years. They are going to build it into this bill. The President has said that he wants—he has said multiple times it is one of his goals to lower the incidence of abortion. This bill, if we pass it, will provide, for the first time in 30 years, taxpayer funding of abortion and will expand abortions—counter to what the President has said multiple times.

Nobody who is pro-life should vote for this bill. This is a radical expansion of abortion funding. It is a radical expansion of abortion. I was and remain very disappointed that the Senate leadership and my Democratic colleagues have attempted to insert radical abortion policy through the Democratic health care bill. Abortion is not health care. Any Senator who votes on the motion to proceed to this health care bill is voting in favor of abortion and the expansion of abortion and against life.

This is the biggest pro-life vote in the Senate in years. This will have more impact on abortions in the United States—an expansion of it—than anything we have seen in years. We have been on a downward trajectory on abortion because both sides have agreed; Democrats have said abortions should be safe, legal, and rare. Former President Clinton and others have said this will make taxpayer funding of abortion—this will expand it. And there is nothing rare about it.

Relevant abortion language in the health care bill to which I am referring could be found on pages 116 to 124. The National Right to Life Committee described the language and said it is completely unacceptable. The Democratic health care bill would explicitly authorize abortion to be covered under the government option, and there must be abortion coverage in every insurance market in the country. The abortion language included in the bill is a radical departure from over 30 years of bipartisan Federal policy prohibiting Federal taxpayer dollars from paying for elective abortions. The language in the bill explicitly authorizes the Secretary of Health and Human Services to include abortion in the public option and permits government subsidies in plans that pay for abortion. We have had a long dispute in Congress and in this body about abortion. We have not had a dispute to near that degree—some, but not near the level of dispute on the taxpayer funding of abortion, because most people are opposed to that—most people in America. They may say, OK, I am all right with abortion, but I don't support Federal taxpayer funding of it. That has been a broad, bipartisan support here for some time. It is explicitly in this bill. It is the Capps language. It is commonly referred to as that. It is in the Senate bill and contains a clever accounting gimmick that proponents say separates private and public funds for abortion coverage.

However, it has been proven that the Capps measure would include both abortion coverage and funding in the government-run public option, as well as for those plans in the insurance exchange.

The only acceptable abortion language is the Stupak-Pitts amendment that passed the House this fall with a quarter of the Democrat caucus voting for it—64 Democrats voted for the Stupak-Pitts compromise language. Representative Bart Stupak, the Democratic author, tailored the true compromise amendment on abortion with the principles set forth in the Hyde amendment, which has been the longstanding position of the Congress.

The Hyde amendment simply says we will not use Federal funds for abortion, which is what a vast majority of Americans support. The Hyde amendment has always enjoyed bipartisan support since its inception in 1977, over three decades ago.

What we should have in the health bill is language that applies the Hyde amendment as it already applies to all other federally funded health care programs, including SCHIP, Medicare, Medicaid, Indian health services, veterans health, military health care programs, and the Federal Employees Health Benefits Program. That is what should be in this.

Representative STUPAK explained the issue very clearly in an op-ed. He wrote yesterday:

> The Capps amendment [which is the basis of the Senate language] departed from Hyde in several important and troubling ways: by mandating that at least one plan in the health insurance exchange provide abortion coverage, by requiring a minimum $1 monthly charge for all covered individuals that would go toward paying for abortions and by allowing individuals receiving federal affordability credits to purchase health insurance plans that cover abortion . . . Hyde currently prohibits direct federal funding of abortion . . . The Stupak amendment is a continuation of this policy—nothing more, nothing less.

I commend Representative STUPAK for his hard work and ability to reach across the aisle to engage his Democratic and Republican colleagues on this issue. A quarter of the Democrats found the Stupak-Pitts compromise worthy of support. But a majority of the American people support keeping the Hyde principles in the Senate health care bill.

I hope we can convince our colleagues in the Senate to follow Mr. STUPAK's lead and do the right thing and vote against the motion to proceed. Voting for the motion to proceed is to endorse the Capps language, which is an expansion of Federal taxpayer funding of abortion.

The American people agree with the Stupak compromise, not the phony language in the Senate bill that would federally fund abortions.

The American people agree it is wrong to smuggle radical abortion policy into this health care bill. The American people agree we should not allow funds to flow from a U.S. Treasury account to reimburse for abortion services.

A CNN/Opinion Research Corporation poll showed that more than 6 in 10 Americans favor the Stupak-Pitts prohibition on the use of Federal funds for abortion. A recent study conducted by International Communications Research found that more than two-thirds of Americans are opposed to using Federal dollars to fund abortion. The American people feel this way because they know that forcing taxpayers to fund abortions is fiscally irresponsible and morally indefensible.

Beyond the funding issue, the Senate bill also does not include the codification of the Hyde-Weldon conscience provision. Instead, it replaces real conscience protections with language that violates the human dignity and religious freedom of organizations and religious institutions that have moral objections to participating in abortion.

A provision on page 123 reads:

> No individual health care provider or health care facility may be discriminated against because of a willingness or unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortion.

One other objection for the pro-life community is that there is nothing in the bill that would prevent school-based health clinics from referring for abortion or helping minors make arrangements for abortions without parental knowledge.

The administrators running the Medicaid Program from 1973 to 1976 funded as many as 300,000 abortions per year, until the Hyde amendment was enacted in 1976. In the past, in that period from 1973 to 1977, when there was Federal funding of abortions, the Federal government—the taxpayers—funded as many as 300,000 abortions per year with taxpayer dollars. That was until the Hyde amendment was enacted in 1976, because the American people despise

doing this. They disagree with that. Whether they are pro-choice or pro-life, they don't want taxpayer dollars to go for this. If they are pro-life, they are saying those are my taxpayer dollars and I am funding this, which I so disagree with doing. This is a beautiful, dignified human life, and my dollars are being used to kill it.

When the Commonwealth of Massachusetts recently passed its State-mandated insurance, Commonwealth Care, without an explicit exclusion of abortion, abortions there were also funded immediately. In fact, according to the Commonwealth Care Web site, abortion is considered covered ''outpatient medical care.'' The Federal Government should not go down this road.

As stated earlier, the President has stated on multiple occasions that it is his goal to lower the incidence of abortion. If that is what he wants to do, if we want to do more than pay lipservice to that reality, we should consider the fact that when Federal funding is not available, fewer abortions occur, or when Federal funding is available, as we have seen in the past, many thousands more occur.

Only the Stupak amendment would lower the incidence of abortion. The current language of the Senate bill would accomplish the opposite and increase abortions. If you are a pro-life Senator, you cannot vote for this bill. This is an expansion. You cannot vote for the procedural vote to go to the bill for the expansion that this will do.

In summary, I will make it clear that the Stupak language is what we need to fix the shell game that would allow public funds to pay for the destruction of innocent human life in the Senate health bill. Unfortunately, language currently within the health bill is a nonstarter and is wrong. It doesn't apply to the longstanding principles of the Hyde amendment. Let's maintain the status quo and not get into the business of publicly funding abortions in America.

I urge my colleagues to think seriously about the precedent being lined out in the health bill if the Senate decides it is going to force the American public to pay for abortions, whether they agree or not.

I urge my colleagues to vote against the motion to proceed to this health care bill. This is not just a procedural vote. It is an enormously important vote because it is the one opportunity for the Senate to stand for life and against taxpayer funding of abortions. Voting in favor of this motion to proceed is a vote against life.

I remind my colleagues, this is the biggest vote on abortion in the Senate in years. Let's not change our current Federal policy to force the American public to pay for government-subsidized abortions, please.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. Mr. President, I rise in this great Chamber of debate, this greatest deliberative body, to speak about the upcoming debate on health care on which, thanks to the extraordinary work of our leader, Senator HARRY REID, we are about to embark. I am here to urge that we in the Senate lift the tone and direction of our national debate.

Let me start by saying I appreciate and enjoy vigorous debate. Senator BYRD gave an eloquent eulogy for Senator Kennedy, noting that our beloved, late colleague saw politics as a contact sport. There is nothing wrong with a clean hit in the public arena. Nobody here needs to tiptoe around. A well-marshaled argument, buttressed by the facts, is a beautiful thing, even when delivered hot. Dynamic and vigorous debate is how a democracy sorts through the thorny issues we face. What an ideal time now would be for strong, reasoned arguments about health care reform in the Senate in the coming weeks.

Contrast what we have heard for months on the airwaves and in town-hall meetings: charged buzzwords such as ''death panels,'' ''socialized medicine,'' ''benefits for illegal immigrants,'' and ''rationing of care''—words that inflame passions and ignite fear rather than making a reasoned case for advancing an alternative.

Worse, these messages have been delivered with a crudeness and a venom; for example, the President portrayed with a Hitler mustache. That is unprecedented in my experience in government. Many of us felt President Bush was less than truthful, but for 8 years, no one yelled out in a State of the Union Address: ''You lie.'' Yet this September, 179 Republicans in the House of Representatives of the Congress of the United States voted to support their heckler comrade.

The media, so often in our history a check on the use of falsehood and distortion by powerful interests, has too often been a part of the problem, not part of the solution. For significant parts of the media, facts do not need to be true to be repeated, conclusions do not need to be logical to be reached, and spin is the order of the day.

FOX News the other day launched an attack on President Obama for having too many so-called czars. Let's set aside that George Bush had more. FOX showed a graphic of 30 officials whom, it said, ''didn't have to be confirmed,'' 9 of whom actually had been confirmed by this Senate. My young niece did a better fact-checking job at her summer job for a literary magazine than that.

Recently, FOX used footage from a different event to make attendance at a Republican rally look bigger. A constituent sent me a letter expressing concern that she heard on the Glenn Beck show that President Obama was planning a national civilian security force that would report only to him, akin to the Nazi SS. What did I think of that, she asked. This was a well-meaning Rhode Islander.

We checked, and it turned out the President had given a speech about expanding the Peace Corps, AmeriCorps, the Foreign Service, and other government service programs. I ask you, Mr. President, in what fevered and distorted imagination does national service to AmeriCorps, to the Peace Corps or in the Foreign Service become an SS-type militia? Yet Mr. Beck actually said that.

Another rightwing piece on President Obama's support for AmeriCorps suggested a parallel with Hitler Youth.

Its author said:

> If I need to make my point, I'm going to make it in a provocative manner, because that's how it attracts attention.

The truth should provide terrets through which arguments must run—but not now. As a very well-regarded Philadelphia columnist wrote of the Republican right, ''if they can get some mileage . . . nothing else matters.''

He went on to decry the ''conservative paranoia'' and ''lunacy'' afoot in our national debate.

The editor of the Manchester Journal Inquirer editorial page wrote of the GOP, which he called this ''once great and now mostly shameful party,'' that it ''has gone crazy,'' that it is ''more and more dominated by the lunatic fringe,'' and that it has ''poisoned itself with hate.''

He concluded:

> They no longer want to govern. They want to emote.

The respected Maureen Dowd of the New York Times, in her column eulogizing her friend, the late William Safire, lamented the ''vile and vitriol of today's howling pack of conservative pundits.''

Even the staid, old U.S. Chamber of Commerce has descended into such irresponsible advocacy that Apple, PG&E, Levi Strauss & Company, PNM Resources, Nike, and Exelon have distanced themselves from it, PNM citing the Chamber's ''recent theatrics.''

There comes a point when debate unhinges from reality. When that happens, you leave the sunlit fields of argument and deliberation and you enter a shadowy realm of sloganeering, fear mongering, and propaganda. In these dark and twisted Halls, democracy suffers as debate seeks to scare people or deceive them rather than informing or explaining. It is so easy if you want to go there.

Of course, you can get seniors up in arms by telling them their final years will be subject to the whims of death panels. Of course, you can inflame the passions of people without health insurance by telling them their tax dollars will go to provide health insurance to illegal immigrants. Of course, you can provoke people's attention by telling them reform will keep them from

their doctors. But none of these claims is true.

The respected head of the Mayo Clinic recently described the health care antics we have witnessed as ''mud'' and ''scare tactics.''

A well-regarded Washington Post writer with a quarter century of experience, married to a Bush administration official, noted about the House health care bill: ''The appalling amount of misinformation being peddled by its opponents.'' She called it a ''flood of sheer factual misstatements about the health-care bill'' and noted of the House Republicans that ''[t}he falsehood-peddling began at the top. . . .''

Her ultimate question was this:

Are the Republican arguments against the bill so weak that they have to resort to these misrepresentations and distortions?

Where does this lead? The ill-informed, the gullible, those already on the razor's edge of anger about the very election of this President may well be tipped by all this poisonous propaganda into actions we would all regret—I hope we would all regret. When do anger and frustration fomented in this debate begin to spill over into dangerous or violent acts? When does some havoc occur, such that we all look back with sorrow and wish we had better leashed our dogs of rhetorical war? Where do we restore civility and reason to the health care debate before it gets too late?

I say history's charge to the Senate is to rise above the poison of our recent public debate. This greatest deliberative body is intended to set an example for public argument, not get swept into its downward spiral. We may find agreement; we may not. At the end of the day, some of us may be happy and others of us not. Some may lose and some may win. But the Senate will go on.

After the health care debate has raged through this great Chamber, other debates will follow, and ultimately what will matter more than the outcome of those debates is whether our proud American democracy has come through them with its head held high.

When debate and our democracy lose its footing in the facts, when things are said for public effect without regard to whether they are true, when the din of strife blots out the voice of reason, something of great and lasting value to America is sacrificed.

Democracy does not prosper on a diet of propaganda and fear. The current tone of much of our debate is, frankly, unworthy of us. Most in America agree something must be done to fix our health care system. If we can agree something must be done, it should not be difficult to debate our differences as to what must be done in a civil, thoughtful, and factual manner. Let the Senate be the place where we take a stand, rejecting the incivility and falsehood that has surrounded us on our public airwaves. Through history, that is what this Chamber, at its best, has always achieved and needs now to achieve again.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the Senate resume the motion to proceed to H.R. 3590 at 10 a.m. under the debate limitations previously ordered.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 a.m. tomorrow.

Thereupon, the Senate, at 7:51 p.m., adjourned until Friday, November 20, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

BROADCASTING BOARD OF GOVERNORS

VICTOR H. ASHE, OF TENNESSEE, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE JAMES K. GLASSMAN, RESIGNED.

WALTER ISAACSON, OF LOUISIANA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE STEVEN J. SIMMONS, TERM EXPIRED.

WALTER ISAACSON, OF LOUISIANA, TO BE CHAIRMAN OF THE BROADCASTING BOARD OF GOVERNORS, VICE JAMES K. GLASSMAN, RESIGNED.

MICHAEL LYNTON, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE MARK MCKINNON, TERM EXPIRED.

SUSAN MCCUE, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2011, VICE JOAQUIN F. BLAYA, TERM EXPIRED.

MICHAEL P. MEEHAN, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE D. JEFFREY HIRSCHBERG, TERM EXPIRED.

DENNIS MULHAUPT, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2011, VICE BLANQUITA WALSH CULLUM, TERM EXPIRED.

DANA M. PERINO, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE EDWARD E. KAUFMAN, RESIGNED.

S. ENDERS WIMBUSH, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE NORMAN J. PATTIZ, TERM EXPIRED.

CONFIRMATION

Executive nomination confirmed by the Senate, Thursday, November 19, 2009:

THE JUDICIARY

DAVID F. HAMILTON, OF INDIANA, TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT.