Affordable Health Care For America Act
Section-by-Section Analysis

DIVISION A – AFFORDABLE HEALTH CARE CHOICES

Sec. 100. Purpose; table of contents of division; general definitions. Provides an outline of the bill structure and a glossary of terms used throughout.

TITLE I—IMMEDIATE REFORMS

Sec. 101. National High-Risk Pool Program. Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months or denied a policy because of pre-existing conditions. The funding for this program is capped at $5 million and it terminates when those funds are exhausted or when the Health Insurance Exchange is up and running.

Sec. 102. Ensuring value and lower premiums. Amends the Public Health Service Act to require health insurance issuers in the small and large group market to meet a medical loss ratio of not less than 85%, effective for plan years beginning January 1, 2010. Directs the Secretary to require that plans in the individual market also meet a medical loss ratio of not less than 85% so long as it does not destabilize the existing individual market. If plans exceed that limit, rebates to enrollees are required. In determining the methodology for the medical loss ratio, the Secretary is to design it to ensure adequate participation by issuers, competition in the market, and value for consumers.

Sec. 103. Ending health insurance rescission abuse. Prohibits health insurance companies from rescinding coverage except in instances of fraud and requires independent review of any rescission determination, effective July 1, 2010.

Sec. 104. Sunshine on price gouging by health insurance issuers. Establishes an annual review process for increases in health insurance premiums by the Secretary of HHS in conjunction with the States that requires insurers to submit a justification for any premium increases prior to implementation. Effective for plan years beginning January 1,2010.

Sec. 105. Requiring the Option of Extension of Dependent Coverage for Uninsured Young Adults. Requires health insurers to allow individuals through age 26, not otherwise covered, to remain on their parents' health insurance at their parents' choice for plan years beginning January 1, 2010.

Sec. 106. Limitations on pre-existing condition exclusions by group health plans in advance of applicability of new prohibition of pre-existing condition exclusions. Prior to the bill's complete prohibition on pre-existing condition exclusions beginning in 2013, this provision shortens the time that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the time plans may exclude coverage of certain benefits generally from 12 months to 3 months. Effective for plan years beginning January 1, 2010.

Sec. 107. Prohibiting acts of domestic violence from being treated as pre-existing conditions. Prohibits insurers from limiting or denying coverage based on acts stemming from domestic violence for plan years beginning January 1, 2010.

Sec. 108. Ending health insurance denials and delays of unnecessary treatment for children with deformities. Requires plans to pay for reconstructive surgery for children with deformities for plan years beginning January 1, 2010.

Sec. 109. Elimination of lifetime aggregate limits. Prohibits health insurers from utilizing lifetime limits on benefits for plan years beginning January 1, 2010.

Sec 110. Prohibition against post-retirement reductions of retiree health benefits by group health plans. Prohibits employers from reducing retiree health benefits below what was offered to retirees at the time of their retirement unless reductions are also made to active workers' health benefits. Effective as of date of enactment.

Sec. 111. Reinsurance program for retirees. Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. The program reimburses participating employment-based plans for 80% of the cost of benefits provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne directly by participants and beneficiaries. The act appropriates $10 billion for this fund and those funds are available until expended.

Sec. 112. Wellness Program Grants. Establishes a grant program for small employers to assist with the creation of employee wellness programs that promote healthy behaviors in a non-discriminatory manner.

Sec. 113. Extension of COBRA continuation coverage. Extends COBRA eligibility to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running.

Sec. 114. State Health Access Program Grants. Builds on an existing grant program to enhance incentives for states to move forward with a variety of health reform initiatives that would expand access to affordable health care for the uninsured prior to 2013.

Sec. 115. Administrative simplification. Requires the Secretary of HHS to adopt standards for typical transactions between insurers and providers such as claims, eligibility, enrollment, and prior authorization building on the standards in the Health Insurance Portability and Accountability Act of 1996. It establishes implementation and enforcement mechanisms for such standards.

TITLE II – PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

SUBTITLE A – GENERAL STANDARDS

Sec. 201. Requirements reforming health insurance marketplace. Broadly outlines the standards for reforming the health insurance marketplace.

Sec. 202. Protecting the choice to keep current coverage. Allows the maintenance of current individual health plans as "grandfathered plans" and provides for a five year grace period for current group health plans to meet specified standards (insurance and benefit requirements).

SUBTITLE B – STANDARDS GUARANTEEING ACCESS TO AFFORDABLE COVERAGE

Sec. 211. Prohibiting pre-existing condition exclusions. Prohibits the application of pre-existing condition exclusions.

Sec. 212. Guaranteed issue and renewal for insured plans and prohibiting rescissions. Requires guaranteed issue (no one can be denied health insurance) and renewal of insurance policies and prohibits the use of rescissions except in instances of fraud.

Sec. 213. Insurance rating rules. Limits age rating to a ratio of 2 to 1; allows variation based on geographic area and family size as permitted by state insurance commissioners and the Health Choices Commissioner.

Requires a study and reports by the Health Choices Commissioner describing the differences between insured and self-insured plans and providing recommendations as appropriate to ensure that the law does not create incentives for small and midsize employers to self insure or create adverse selection in the risk pools of insured plans.

Sec. 214. Nondiscrimination in benefits; **parity in mental health and substance abuse disorder benefits.** Provides authority to the Health Choices Commissioner to set non-discrimination rules and ensures that mental health and substance use disorder parity and genetic nondiscrimination laws apply to qualified health benefits plans.

Sec. 215. Ensuring adequacy of provider networks. Provides authority to the Health Choices Commissioner to set network adequacy standards that qualified plans must meet.

Sec. 216. Requiring the option of extension of dependent coverage for uninsured young adults. Permanently extends the requirement that health plans allow individuals through age 26, not otherwise covered, to remain on their parents' health insurance at their parents' choice.

Sec. 217. Consistency of costs and coverage under qualified health benefits plans during plan year. Requires qualified health benefits plans to provide at least 90 days notice in advance of any increase or decrease in coverage, but includes an exception to protect the health and safety of enrollees.

SUBTITLE C – STANDARDS GUARANTEEING ACCESS TO ESSENTIAL BENEFITS

Sec. 221. Coverage of essential benefits package. Requires qualified plans to meet the benefit standards recommended by the Benefits Advisory Committee and adopted by the Secretary of HHS. Plans outside the Exchange must offer at least the essential benefits and others as they choose. Plans within the Exchange must meet the specified benefit packages, including being able to offer additional benefits in a specified tier. Allows for the continued offering of separate excepted benefits packages, as in current law, outside of the Exchange.

Sec. 222. Essential benefits package defined. Outlines the broad categories of benefits required to be included in the essential benefits package, prohibits any cost-sharing for preventive benefits (including well child and well baby care), and limits annual out-of-pocket spending in the essential benefits package to $5,000 for an individual and $10,000 (indexed to CPI) for a family. Defines the initial essential benefit package as being actuarially equivalent to 70% of the package if there were no cost-sharing imposed. Requires the Secretary to assess adding counseling for domestic violence as part of the behavioral health or primary care visit. Prohibits abortion services from being made part of essential benefits package. Prohibits federal funds from being used to pay for abortion (except in cases of rape, incest, and to save life of the woman). Only private premium dollars can be used to provide abortion coverage. Where abortion coverage is provided, funds for this purpose must be segregated from other funds, including affordability credits. Includes a report regarding the need and cost of providing oral health care to adults as part of the essential benefits package. In the developing the essential benefit package, the Secretary shall support the need for assessment and counseling for domestic violence as part of the behavioral health assessment or primary care visit.

Sec. 223. Health Benefits Advisory Committee. Establishes a Health Benefits Advisory Committee, chaired by the Surgeon General, with private members appointed by the President, the Comptroller General, and representatives of relevant federal agencies. The Advisory Committee will make recommendations to the Secretary of HHS regarding the details of covered health benefits as outlined in Sec. 222, including the establishment of the three tiers of coverage: basic, enhanced and premium.

Sec. 224. Process for adoption of recommendations; adoption of benefit standards. Establishes the timeline for the initial adoption of benefits by the Secretary of HHS and the periodic updating of standards in the future.

SUBTITLE D – ADDITIONAL CONSUMER PROTECTIONS

Sec. 231. Requiring fair marketing practices by health insurers. Provides the Health Choices Commissioner with the authority to define marketing standards that qualified plans are required to meet.

Sec. 232. Requiring fair grievance and appeals mechanisms. Requires each qualified plan to meet standards defined by the Health Choices Commissioner for timely internal grievance and appeals mechanisms and to establish an external review process that provides for an impartial, independent and de novo review of denied claims. The determination is binding.

Sec. 233. Requiring information transparency and plan disclosure. Requires qualified plans to meet standards established by the Health Choices Commissioner relating to transparency and timely disclosure of plan documents and information, including providing health care providers with information regarding their payments. It also requires the use of plain language in the disclosures (including the issuance of guidance as to what "plain language" means) and advance notice of changes to the plans.

Sec. 234. Application to qualified health benefits plans not offered through the Health Insurance Exchange. Provides flexibility to the Health Choices Commissioner to decide what protections of sections 231-233 should apply to qualified plans outside of the Health Insurance Exchange.

Sec. 235. Timely payment of claims. Applies Medicare's timely payment of claims standards to the plans offering coverage through the Exchange.

Sec. 236. Standardized rules for coordination and subrogation of benefits. Requires the Health Choices Commissioner to establish standards for the coordination of benefits involving individuals and multiple sources of coverage (like workers' compensation coordination) and reimbursement of health care payments by insurers in cases where an individual recovers money.

Sec. 237. Application of Administrative Simplification. Requires insurers and providers to use common standards for transactions such as claims payment, eligibility and enrollment building on the Health Insurance Portability and Accountability Act of 1996.

Sec. 238. State prohibitions on discrimination against health care providers. Clarifies that this Act does not supersede state laws that prohibit health plans from discriminating against health care providers acting within the scope of their licenses or certifications.

Sec. 239. Protection of physician prescriber information. Requires a study by the Secretary of HHS on the use of physician prescriber information in sales and marketing practices of pharmaceutical manufacturers and make recommendations as to the actions needed by Congress or the Secretary to protect providers from biased marketing and sales practices.

Sec. 240. Dissemination of advance care planning information. Provides that health insurers in the Exchange present enrollees with information about resources available for advanced care planning which is voluntary to the individual.

SUBTITLE E – GOVERNANCE

Sec. 241. Health Choices Administration; Health Choices Commissioner. Establishes the Health Choices Administration, an independent executive branch agency. The Health Choices Commissioner is appointed by the President.

Sec. 242. Duties and authority of Commissioner. The Health Choices Commissioner carries out functions including: establishment of qualified plan standards, establishment and operation of the Health Insurance

Exchange, administration of affordability credits, and additional functions as laid out within the bill. The Commissioner can collect data necessary to carry out his or her duties and to promote quality and value and address disparities in health care. Such information can also be shared with HHS. The Commissioner also has oversight and enforcement authority including the authority to impose sanctions and suspend enrollment of a plan. This authority requires the Commissioner to coordinate with the Department of HHS, the Department of Labor and state insurance regulators.

Sec. 243. Consultation and coordination. Requires the Health Choices Commissioner to consult with other regulatory bodies and state and federal agencies in carrying out his or her duties and to ensure appropriate oversight and enforcement.

Sec. 244. Health Insurance Ombudsman. Establishes a Qualified Health Benefits Plan Ombudsman to assist individuals in navigating the new health reform system and report to Congress on recommendations for improvements in administration of the program.

SUBTITLE F – RELATION TO OTHER REQUIREMENTS; MISCELLANEOUS

Sec. 251. Relation to other requirements. Makes clear that this act does not supersede COBRA ,HIPAA or state laws, including mental health parity and the genetic nondiscrimination act, unless their requirements prevent the application of a requirement of this title. Preserves individual rights under State law.

Sec. 252. Prohibiting discrimination in health care. Prohibits discrimination by health insurers with regard to the provision of high quality care or services.

Sec. 253. Whistleblower protection. Protects employees from retaliation by their employer for the reporting of any violations of this act and provides remedies for such retaliation in accordance with existing law in the Consumer Product Safety Act.

Sec. 254. Construction regarding collective bargaining. Preserves statutory obligations of employers to collectively bargain with employee representatives over health care.

Sec. 255. Severability. Provides that if any part of this act is found unconstitutional, that other parts of the act shall not be affected.

Sec. 256. Treatment of Hawaii prepaid health care act. Clarifies that this Act doesn't change Hawaii's existing ERISA waiver for their state-based health reform as long as the Secretary of Labor determines that such coverage is at least substantially equivalent to the coverage required under this Act. Also requires the Health Choices Commissioner to work with Hawaii to coordinate their state program and this new Act.

Sec. 257. Actions by state attorneys general. Clarifies that state attorneys general have authority to help enforce this act.

Sec. 258. Application of state and federal laws regarding abortion. Makes clear that nothing in this act pre-empts state laws with regard to abortion nor changes existing federal laws regarding conscience protections, willingness or refusal to provide abortion, and discrimination on the basis of such willingness or refusal.

Sec. 259. Nondiscrimination on abortion and respect for rights of conscience. No federal agency, program, or any state or local government that receives financial assistance under this act may discriminate against a provider on the basis of whether the provide coverage or refer for abortion services.

Sec. 260. Authority of Federal Trade Commission to Conduct Study. Authorizes the Federal Trade Commission to include authority to conduct studies and prepare reports on health insurance plans.

Sec. 261. Construction regarding standard of care. Clarifies that provisions in this Act relating to delivery system reform, reducing hospital acquired infections, and other provisions shall not be used to establish the standard or duty of care in a malpractice suit.

Sec. 262. Restoring application of anti-trust laws to health insurers. Removes the anti-trust exemption for health insurers and medical malpractice insurers.

Sec. 263. Study and report on methods to increase EHR use by small health care providers. Requires the Secretary of Health and Human Services to conduct a study of potential methods to increase the use of qualified electronic health records by small providers including higher reimbursement rates, training, and education.

TITLE III —HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

SUBTITLE A – HEALTH INSURANCE EXCHANGE

Sec. 301. Establishment of Health Insurance Exchange; outline of duties; definitions. Establishes a Health Insurance Exchange under the purview of the Health Choices Administration that will facilitate the offering of health insurance choices. The Health Choices Commissioner establishes a process through which to obtain bids, negotiate and enter into contracts with qualified plans, and ensure that the different levels of benefits are offered with appropriate oversight and enforcement. The Commissioner also facilitates outreach and enrollment, creates and operates a risk pooling mechanism, and ensures consumer protections.

Sec. 302. Exchange-eligible individuals and employers. Defines who is eligible for participation in the Health Insurance Exchange including employers and individuals. In year one, individuals not enrolled in other acceptable coverage are allowed into the Exchange as well as small employers with 25 or fewer employees. In year two, employers with 50 and fewer employees are allowed into the Exchange. In year three, the Commissioner is, at a minimum, required to open the Exchange to employers with 100 and fewer employees, but is permitted from this year forward to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange.

Defines acceptable coverage to include enrollment in other qualified coverage and most other federal health programs.

Medicaid-eligible individuals will be enrolled in Medicaid, not the Exchange.

Once an individual or an employer enrolls in coverage through the Exchange, they remain eligible for Exchange coverage even if circumstances change that would otherwise exclude them.

Requires that employers who offer coverage through the Exchange contribute at least the required contribution toward such coverage and permit their employees the freedom to choose any plan within the Exchange.

Requires the Commissioner to conduct periodic surveys of Exchange-eligible individuals and employers to measure satisfaction.

Requires the Commissioner to conduct a study regarding access to the Exchange to determine if there are significant groups and types of individuals and employers who are not Exchange eligible, but who would have improved benefits and affordability if made eligible. The report is due in year three and year six of the Exchange and continued thereafter. It is to include recommendations as appropriate for changes to the eligibility standards.

Sec. 303. Benefits package levels. The Health Choices Commissioner specifies the benefits that must be made available in each year – including a requirement that each participating plan provide one basic plan in each service

area in which they operate. It is then optional for the plan to offer one enhanced and one premium plan. The differences between the three main plans (i.e. basic, enhanced and premium) are the levels of cost-sharing required, not the benefits covered. The Commissioner shall establish a permissible range of cost-sharing variation that is not to exceed plus or minus 10% with regard to each benefit category.

There is a fourth tier called premium-plus. In this package, plans can offer extra benefits like dental or vision coverage for adults, or other non-covered benefits. To ensure consumers know what they are paying extra for, these packages must detail the cost of the extra benefits separately. Plans may offer multiple premium-plus options.

States can require the application of state benefit mandates to all Exchange participating plans, but only if there is an agreement with the Commissioner that the state will reimburse the Commissioner for any additional costs of affordability credits in that state due to the State benefit requirements.

Sec. 304. Contracts for the offering of Exchange-participating health benefits plans. Lays out the responsibilities for the Health Choices Commissioner's contracting authority including solicitation of bids, negotiation with plans and the entering into contracts with approved plans (that will be for at least one year of duration and can be automatically renewed). Requirements include that plans be licensed in the state in which they will do business, abide by data reporting requirements as outlined by the Commissioner, provide for the implementation of affordability credits, participate in risk pooling, provide for culturally and linguistically appropriate services and communications, and with respect to the basic plan, contract for outpatient services with essential community providers as defined in the 340B program. The Secretary has special authority with respect to Indian enrollees and Indian health care providers.

The Commissioner outlines the bid process, the term of the contract is for a minimum of a year, and the Commissioner enforces network adequacy including an allowance for enrollees to receive services out-of-network at no greater cost if the provider network does not meet the standards for adequacy. Plans must also justify proposed premiums or premium increases and through this rate review the Commissioner has the authority to deny excessive premiums or premium increases.

The Commissioner is required to establish processes to oversee, monitor, and enforce requirements on the plans. The Commissioner has the authority to terminate plans that fail to meet the required standards.

Sec. 305. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan. Requires the Health Choices Commissioner to conduct outreach and enrollment activities to ensure Exchange-eligible individuals and businesses are enrolled into the Exchange in a timely manner, including a toll-free hotline, maintenance of a website, creation of outreach materials written in culturally and linguistically appropriate language, and community locations for enrollment. Sets up an annual open enrollment period as well as special enrollment periods for special circumstances. Requires the Commissioner to create an auto-enrollment process for individuals who are Exchange-eligible but have not selected a plan.

The Commissioner provides for broad dissemination of information on Exchange-participating health plans in a comparative manner and can work with other appropriate entities to ensure the dissemination of this information.

Establishes rules to ensure continuity of coverage for certain newborns in Medicaid and for children eligible for CHIP. Requires the Commissioner to enter into memorandums of understanding with state Medicaid agencies to coordinate enrollment in Medicaid and the Exchange for Medicaid-eligible individuals.

Requires the Health Choices Commissioner to consult with the Small Business Administration and small employer benefit arrangements to provide consumer information, outreach, counseling and technical assistance with respect to participating in the Health Insurance Exchange.

Sec. 306. Other functions. The Health Choices Commissioner coordinates affordability credits and risk-pooling. In order to prevent waste, fraud and abuse, institutes a special inspector general to oversee operation of the program.

Sec. 307. Health Insurance Exchange Trust Fund. Creates a Health Insurance Trust Fund to provide necessary funding for the Health Choices Administration.

Sec. 308. Optional operation of State-based health insurance exchanges. Permits states to offer their own Exchange or join with a group of states to create their own exchange in lieu of the federal Health Insurance Exchange, provided that the state(s) perform all of the duties of the federal Exchange as approved by the Health Choices Commissioner. The Commissioner has authority to terminate state exchanges if they are not meeting their obligations. Presumes that any State operating an Exchange prior to 2010 is allowed to continue doing so.

Sec. 309. Interstate health insurance compacts. Effective January 1, 2015, would allow 2 or more States to form Health Care Choice Compacts to facilitate the purchase of individual health insurance across State lines. Calls on the National Association of Insurance Commissioners to develop model guidelines for such compacts. Ensures that such compacts require licensure in each state and maintains authority of the State in which a covered individual resides to protect the individual. Allows States to apply for grants from the Secretary of HHS to help implement such compacts.

Sec. 310. Health Insurance Cooperatives. Requires the Health Choices Commissioner to establish a "Consumer Operated and Oriented Plan Program" known as the CO-OP Program, to assist organizations that wish to start up a non-profit health insurance cooperatives and provides start up loans for these organizations.

Sec. 311. Retention of DOD and VA Authority. Makes clear that nothing in this act interferes with the Department of Veterans' Affairs or Department of Defense's existing authorities.

SUBTITLE B – PUBLIC HEALTH INSURANCE OPTION

Sec. 321. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan. Requires the Secretary of Health and Human Services to develop a public health insurance option to be offered starting in 2013 as a plan choice within the Health Insurance Exchange. It participates on a level playing field with private plan choices. Like private plans, it must offer the same benefits, abide by the same insurance market reforms, follow provider network requirements and other consumer protections.

Sec. 322. Premiums and financing. Premiums for the public option are geographically-adjusted and are required to be set so as to fully cover the cost of coverage as well as administrative costs of the plan. This includes a requirement that the public option, like private plans, include a contingency margin in its premium to cover unexpected cost variations. In order to establish the public option, there is an initial appropriation of $2 billion for administrative costs and in order to provide for initial claims reserves before the collection of premiums such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment. These start up funds are amortized into the premiums for the public option to be recouped over the first 10 years of operation. The plan must be self-sustaining after that initial funding.

Sec. 323. Payment rates for items and services. The Secretary negotiates payment for health care providers and items and services, including prescription drugs, for the public health insurance option. Medicare providers are presumed to be participating in the public option unless they opt out. There are no penalties for opting out and providers have at least a one-year period prior to the beginning of the pubic option to opt out.

Sec. 324. Modernized payment initiatives and delivery system reform. The Secretary shall evaluate the progress of payment and delivery system reforms and apply them to the public option and how it pays for medical

services to promote better quality and more efficient use of medical care. Such payment changes must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care.

Sec. 325. Provider participation. Provides the Secretary of HHS with the authority to develop conditions of participation for the public health insurance option. Providers must be licensed or otherwise recognized in the state in which they do business. Physician participation comes in two types: preferred physicians are those physicians who agree to accept the public option's payment rate (without regard to cost-sharing) as payment in full, participating non-preferred physicians are those who agree not to impose charges in excess of the balance billing limitations as set forth by the Secretary. Providers must be excluded from participating in the public option if they are excluded from other federal health programs.

Sec. 326. Application of fraud and abuse provisions. Applies Medicare's anti-fraud and abuse protections to the public health insurance option.

Sec. 327. Application of HIPAA insurance requirements. Applies consumer protection standards put forth under the Health Insurance Portability and Access Act to the public health insurance option.

Sec. 328. Application of health information privacy, security, and electronic transaction requirements. Assures that privacy protections of existing law apply to the public health insurance option as well.

Sec. 329. Enrollment in Public Health Insurance Option is voluntary. Clarifies that no one is required to participate in the public health insurance option – it is a voluntary choice.

Sec. 330. Enrollment in Public Health Insurance Option by Members of Congress. Makes clear that Members of Congress are eligible to join the public health insurance option.

Sec. 331. Reimbursement of Secretary of Veterans Affairs. Calls on the Secretary of HHS to enter into a memorandum of understanding with the Secretary of Veterans Affairs regarding the recovery of costs related to non-service-connected care or services that are provided by VA to an enrollee in the public health insurance option.

SUBTITLE C – INDIVIDUAL AFFORDABILITY CREDITS

Sec. 341. Availability through Health Insurance Exchange. Creates affordability credits to ensure that people with incomes up to 400% of federal poverty have affordable health coverage. These credits are phased out according to a schedule defined in the act as individual and family incomes up to 400% of poverty and the credits apply only to Exchange-participating plans. Affordability credits reduce the costs of both premium and annual out-of-pocket spending. Individuals apply through the Commissioner or Health Insurance Exchange for the credits, or through other entities approved by the Commissioner. The Commissioner, through an agreement with the Commissioner of Social Security, must conduct a verification process to confirm citizenship or lawful presence in the United States before any individual is eligible for affordability credits. In the first two years, affordability credits can only be used to purchase a basic plan. After that, the Commissioner establishes a process to allow them to be used for enhanced and premium plans in a way that makes clear the individuals who select those options will be responsible for any difference in costs.

Sec. 342. Affordability credit eligible individual. In order to receive affordability credits, individuals must have individual coverage through an Exchange-participating health benefits plan (though not through an employer purchasing coverage through the Exchange). Family and individual incomes must be below 400% of the federal poverty limit to access the affordability credits, and the individual must not be eligible for Medicaid or enrolled in Medicare or other acceptable coverage. In general, employees who are offered employer coverage are ineligible for affordability credits within the Exchange. Beginning in year two, employees who meet an affordability test

showing that coverage under their employer-provided plan would cost more than 12% of income, are eligible to obtain income-based affordability credits in the Exchange.

Sec. 343. Affordability premium credit. The affordability premium amount is calculated on a sliding scale starting at 1.5% of income for those at or below 133% of poverty and phasing out at 12% of income for those at 400% of poverty. The way this phase out works is specifically detailed in the act. The reference premium is the average premium for the three lowest cost basic plans in the area in which the individual resides. There is an out-of-pocket maximum set at $500 for an individual and $1000 for a family at the lowest income tier rising to $5,000 for an individual and $10,000 for a family at the highest income tier for individuals receiving affordability credits.

Sec. 344. Affordability cost-sharing credit. The affordability cost-sharing credit reduces cost-sharing for individuals and families at or below 133% of poverty up to 400% of the federal poverty limit as specified in the act.

Sec. 345. Income determinations. To determine income, the Health Choices Commissioner uses income data from the individual's most recent tax return. The federal poverty level applied is the level in effect as of the date of the application. The Commissioner takes such steps as are appropriate to ensure accuracy of determinations and redeterminations to protect program integrity. Processes are established for individuals with significant changes in income to inform the Commissioner of such change. There are penalties for misrepresentation of income. The Secretary of Health and Human Services is required to conduct a study examining the feasibility and implication of adjusting the application of the federal poverty level for different geographic areas so as to reflect the variations in the cost-of-living among various areas in the country.

Sec. 346. Special rules for application to territories. Creates a process by which a territory can elect to participate in the Health Insurance Exchange and provides up to four billion dollars to fund affordability credits if the territory adopts the insurance reforms, consumer protections, and other requirements for individual and employer responsibility in the Act.

Sec. 347. No Federal payment for undocumented aliens. Prohibits anyone not lawfully present in the United States from obtaining affordability credits.

TITLE IV—SHARED RESPONSIBILITY

SUBTITLE A – INDIVIDUAL RESPONSIBILITY

Sec. 401. Individual responsibility. Cross-references the shared responsibility provision in the Internal Revenue Code where an individual has the choice of maintaining acceptable coverage or paying a tax.

SUBTITLE B – EMPLOYER RESPONSIBILITY

PART 1—Health Coverage Participation Requirements

Sec. 411. Health coverage participation requirements. Provides the rules that apply to an employer that elects to provide health coverage (an "offering employer") in lieu of the payroll contribution that applies to a non-offering employer. An offering employer generally must offer all of its employees the option of selecting individual or family health coverage.

Sec. 412. Employer responsibility to contribute toward employee and dependent coverage. Provides that the minimum employer contribution in the case of an offering employer is 72.5% of the premium for individual coverage, and 65% of the premium for family coverage or a proportional amount for non-fulltime employees. Family coverage for this purpose includes the employee's spouse and qualifying children. Requires employers to

provide for automatic enrollment of their employee into their employment-based health plan with the lowest applicable employee premium.

Sec. 413. Employer contributions in lieu of coverage. Requires an offering employer to contribute to the Exchange for each employee who declines the employer's coverage offer and enters the Exchange via the affordability test outlined in the act. The contribution is generally 8% of the average salary for the employer. Small employers with annual payrolls at or below $500,000, are exempt from this requirement. The contribution phases up from 0-8% between an annual payroll of $500,000 and $750,00, at which point employers are subject to the full 8% contribution requirement.

Sec. 414. Authority related to improper steering. Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage and into coverage offered under the Exchange.

Sec. 415. Impact study on employer responsibility requirements. Requires the Secretary of Labor to conduct a study to examine the effect of the small business exemptions from the employer contribution and to provide recommendations annually after 2012 as to whether these requirements are having detrimental impacts or creating inequities among employers, health plans and enrollees and shall submit recommendations to Congress if the Secretary finds that changes should be made to the law in this regard.

Sec. 416. Study on employer hardship exemption. The Secretaries of Labor, Treasury and Health and Human Services and the Health Choices Commissioner shall together conduct a study to examine whether an employer hardship exemption should be added to the law.

PART 2—Satisfaction of Health Coverage Participation Requirements

Sec. 421. Satisfaction of health coverage participation requirements under the Employee Retirement Income Security Act of 1974. Provides rules under which an employer that is subject to ERISA makes an election to offer health coverage (an "offering employer") in lieu of the payroll tax that applies to a non-offering employer. The employer can make a separate election for full-time employees, non-full time employees, and separate lines of business. The section also provides enforcement authority to the Department of Labor and employees of an offering employer if the employer does not follow the rules that apply to a coverage offer.

Sec. 422. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986. Cross-references the rules in the Internal Revenue Code relating to an employer's election to be an offering employer.

Sec. 423. Satisfaction of health coverage participation requirements under the Public Health Service Act. Provides rules under which an employer that is subject to the Public Health Service Act makes an election to offer health coverage (an "offering employer") in lieu of the payroll tax that applies to a non-offering employer. The employer can make a separate election for full-time employees and non-full time employees. The section also provides remedies to the Department of Health and Human Services and employees of an offering employer if the employer does not follow the rules that apply to a coverage offer.

Sec. 424. Additional rules relating to health coverage participation requirements. Requires the Exchange and the Departments of HHS, Labor, and Treasury to develop coordinated interpretative and enforcement measures with respect to offering employers.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

SUBTITLE A – PROVISIONS RELATING TO HEALTH CARE REFORM

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

Sec. 501. Tax on individuals without acceptable health care coverage. Provides for a 2.5% additional tax on the modified adjusted gross income of an individual who does not obtain acceptable health coverage for the individual or dependents claimed on the individual's tax return. Authorizes the Department of Treasury and the Exchange to establish a hardship exemption from the additional tax. Acceptable coverage includes grandfathered individual and employer coverage, certain government coverage (e.g., Medicare, Medicaid, certain coverage provided to veterans, military employees, retirees, and their families, and members of Indian tribes), and coverage obtained pursuant to the Exchange or an employer offer of coverage.

Subpart B—Employer Responsibility

Sec. 511. Election to satisfy health coverage participation requirements. Provides rules under which an employer makes an election to offer health coverage (an "offering employer") in lieu of the payroll tax that applies to a non-offering employer. This section also provides for an excise tax that applies to an offering employer if the employer fails to follow the rules governing an offer of coverage.

Sec. 512. Health care contributions of nonelecting employers. Establishes a payroll tax of 8% of the wages that an employer pays to its employees for employers who choose not to offer coverage. Certain small employers are exempt from this or are subject to a graduated tax rate. An exempt small business is an employer with an annual payroll that does not exceed $500,000. The 8% payroll tax phases in for employers with annual payroll from $500,000 through $750,000.

PART 2—CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

Sec. 521. Credit for small business employee health coverage expenses. Provides for a tax credit equal to 50% of the amount paid by a small employer for employee health coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees, and is also phased out in the case of an employer with average wages of $20,000 to $40,000 per year. An employer may elect to use the credit for a maximum of 2 taxable years.

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

Sec. 531. Distributions for medicine qualified only if for prescribed drug or insulin. Provides that nontaxable reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts do not include a medicine or drug unless the medicine or drug is prescribed or is insulin.

Sec. 532. Limitation on health flexible spending arrangements under cafeteria plans. Limits salary reduction contributions to health flexible spending arrangements to $2,500 (indexed to the consumer price index).
Sec. 533. Increase in penalty for nonqualified distributions from health savings accounts. Increases the 10 percent penalty on distributions from health savings accounts that are not used to pay for health related expenditures to 20 percent.

Sec. 534. Denial of deduction for Federal subsidies for prescription drug plans which have been excluded from gross income. Certain employers are eligible for Federal subsidies with respect to prescription drug benefits provided to retirees and the subsidies are excluded from gross income. Provision eliminates the ability of employers to deduct expenses for which they are subsidized.

PART 4—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

Sec. 541. Disclosures to carryout health insurance exchange subsidies. Permits the Exchange to receive taxpayer return information from the Internal Revenue Service in order to assist the Exchange in determining subsidy eligibility.

Sec. 542. Offering of exchange-participating health benefit plans through cafeteria plans. Provides that coverage purchased through the Exchange may not be purchased on a pre-tax salary reduction basis unless the purchaser's employer is eligible to offer employer coverage through the Exchange.

Sec. 543. Exclusion from gross income of payments made under reinsurance program for retirees. Provides that subsidies received by an employer or health plan under section 111 of the bill are not includable in gross income.

Sec. 544. CLASS Program treated in same manner as long-term care insurance. Provides that premiums for participation in the CLASS Program, and benefits received under the program, are treated in the same manner as premiums for and benefits under qualified long-term care insurance policies.

Sec. 545. Exclusion from gross income for medical care provided for Indians. Provides that health services and coverage provided by a tribe or tribal organization to a member of the tribe is excluded from gross income.

SUBTITLE B – OTHER REVENUE PROVISIONS

PART 1—GENERAL PROVISIONS

Sec. 551. Surcharge on high income individuals. Establishes a 5.4 percent tax on modified adjusted gross income in excess of $1 million in the case of a joint return ($500,000 in the case of other returns). The tax is estimated to affect only 0.3 percent of all households and only 1.2 percent of sole proprietors, partners, and s-corporation shareholders operating a business.

Sec. 552. Excise tax on medical devices. Establishes a 2.5 percent excise tax on medical devices sold for use in the U.S. The excise tax does not apply to exported devices and does not apply to retail sales of devices.

Sec. 553. Expansion of information reporting requirements. Requires information reporting with respect to payments made in the course of a trade or business to a corporation.

Sec. 554. Delay in application of worldwide allocation of interest. Provision delays the application of a liberalized rule for allocating interest expenses between U.S. and foreign sourced income for purpose of a taxpayer's foreign tax credit limitation.

PART 2—PREVENTION OF TAX AVOIDANCE

Sec. 561. Limitation on treaty benefits for certain deductible payments. Prevents foreign multinational corporations incorporated in tax havens from avoiding tax on income earned in the U.S.

Sec. 562. Codification of economic substance doctrine; penalties. Clarifies the application of the economic substance doctrine, which has been used by courts to deny tax benefits for transactions that lack economic substance.

Sec. 563. Certain large or publicly traded persons made subject to a more likely than not standard for avoiding tax penalties on underpayments. Provides that tax penalties on underpayments by certain large or publicly traded entities cannot be avoided unless the basis for the tax treatment that caused the underpayment is based on a reasonable belief that such tax treatment is more likely than not the proper tax treatment.

PART 3—PARITY IN HEALTH BENEFITS

Sec. 571. Certain health related benefits applicable to spouses and dependents extended to eligible beneficiaries. Extends the exclusion for employer provided health coverage to a person who is eligible for coverage under the employer's plan and who is not a spouse or dependent.

DIVISION B— MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

SUBTITLE A – PROVISIONS RELATED TO MEDICARE PART A

PART 1—Market Basket Updates

Sec. 1101. Skilled nursing facility payment update. Provides for a market basket freeze for the second, third and fourth quarters of fiscal year 2010.

Sec. 1102. Inpatient rehabilitation facility payment update. Provides for a market basket freeze for the second, third and fourth quarters of fiscal year 2010.

Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements. Incorporates a productivity adjustment into the market basket update for inpatient hospitals, psychiatric hospitals and hospice care beginning in 2010 (beginning in 2011 for skilled nursing facilities, inpatient rehabilitation hospitals). Sets a floor for the inpatient hospital market basket update so that the combination of the productivity adjustment and any adjustments for quality reporting or meaningful use of electronic health records cannot cause the market basket update to go below zero.

PART 2—Other Medicare Part A Provisions

Sec. 1111. Payments to skilled nursing facilities. Codifies the recalibration factor included in the FY 2010 Notice of Proposed Rulemaking for the Medicare skilled nursing facility prospective payment system. Provides a budget neutral adjustment within the payment system to improve payment accuracy for non-therapy ancillary services and therapy services, directs the Secretary to analyze payments for non-therapy ancillary services for inclusion in a future SNF case mix reclassification system, and creates an outlier payment for nontherapy ancillary services.

Sec. 1112. Medicare DSH report and payment adjustments in response to coverage expansion. Directs the Secretary to submit a report to Congress by January 1, 2016 on Medicare disproportionate share hospital (DSH) payments. If the uninsured rate drops a certain number of percentage points between 2012 and 2014, directs the Secretary to adjust Medicare DSH payments starting in FY 2017 to the empirically justified level plus an adjustment reflecting uncompensated care costs.

Sec. 1113. Hospice Regulatory Moratorium. Extends a one-year moratorium on regulatory changes that would phase out the budget neutrality adjustment factor for hospice providers to ensure that hospices continue to receive the same wage reimbursement rate for fiscal year 2010.

Sec. 1114. Expanding Physician Assistants' Role in Medicare. Allows physician assistants to order skilled nursing facility care and lists them as an eligible provider for hospice care.

SUBTITLE B—PROVISIONS RELATED TO PART B

PART 1—Physicians' Services

Sec. 1121. Resource-based feedback program for physicians in Medicare. Expands Medicare's physician resource use feedback program to provide for development of a report for national use by 2012, to be followed by significant national dissemination of such report. Starting in 2014, reports are required to be distributed to at least physicians among the top 5% in use of resources.

Sec. 1122. Misvalued codes under the physician fee schedule. Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. Strengthens the Secretary's authority to adjust fees schedule rates that are found to be misvalued or inaccurate.

Sec. 1123. Payments for efficient areas. Provides incentive payments in the Medicare program to physicians practicing in areas that are identified as being the most cost-efficient areas of the country.

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI). Extends through 2012 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates a review process for physicians who choose to have their PQRI submissions reviewed and directs the Secretary to integrate the PQRI program and the "meaningful use" measures used by the health information technology incentive program.

Sec. 1125. Adjustment to Medicare payment localities. Updates the method used to determine the localities used for Medicare's geographic adjustment factor in California, utilizing an approach that is based on metropolitan statistical areas.

PART 2—Market Basket Updates

Sec. 1131. Incorporating productivity adjustment into market basket updates that do not already incorporate such improvements. Incorporates a productivity adjustment into the market basket update for outpatient hospital services beginning in 2010. Sets a floor for the outpatient hospital market basket update so that the combination of the productivity adjustment and any adjustments for quality reporting cannot cause the market basket update to go below zero. Incorporates a productivity adjustment beginning in 2010 for ambulance services, ambulatory surgical centers, and durable medical equipment not subject to competitive bidding. Replaces the existing update for laboratory services of CPI minus 0.5 with an update of CPI less productivity.

PART 3—Other Provisions

Sec. 1141. Rental and purchase of power-driven wheelchairs. Eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. Purchase option for complex rehabilitative power wheelchairs would be maintained.

Sec. 1141A. Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends. Following the rental period of 13 months, this provision allows beneficiaries to return group 3 support surfaces to the original supplier or to elect to take ownership of such equipment. This provision assures that beneficiaries will continue to have access to such item in the event of a recurrent medical need.

Sec. 1142. Extension of payment rule for brachytherapy. Extends payment at cost for brachytherapy for two years through 2011.

Sec. 1143. Home infusion therapy report to Congress. In many situations, Medicare does not cover equipment and services related to home infusion of prescription drugs. This provision directs the Secretary to make recommendations on the most appropriate way for Medicare to cover and pay for home infusion services.

Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data. Directs the Secretary to develop a cost report for ASCs within two years of enactment and to require reporting of cost data by ASCs for cost reporting periods beginning on or after the date when the cost report is developed. Directs the Secretary to require ASCs to submit quality data beginning in 2012.

Sec. 1145. Treatment of certain cancer hospitals. Directs the Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis.

Sec. 1146. Payment for imaging services. Increases the practice expense units for imaging services to reflect a presumed utilization rate of 75% instead of 50%. Excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25% to 50%.

Sec. 1147. Durable medical equipment program improvements. Provides protections for beneficiaries receiving oxygen therapy in the event an oxygen supplier goes out of business. Exempts certain pharmacies and suppliers of eyewear from the surety bond requirement. Exempts certain pharmacies from the need to be accredited to sell diabetic testing supplies and certain other items.

Sec. 1148. MedPAC study and report on bone mass measurement. Instructs MedPAC to conduct a study on the adequacy of Medicare payment for bone mass measurement services under the physician fee schedule.

Sec. 1149A. Payment for biosimilar biological products. Establishes Part B payment methodologies for interchangeable and biosimilar products.

Sec. 1149B. Study and Report on DME competitive bidding process. Instructs the Government Accountability Office to evaluate establishment of a competitive bidding program for manufacturers of durable medical equipment and supplies.

SUBTITLE C—PROVISIONS RELATED TO MEDICARE PARTS A AND B

Sec. 1151. Reducing potentially preventable hospital readmissions. Beginning in fiscal year 2012, adjusts payments for 1886(d) hospitals, critical access hospitals and hospitals paid under 1814(b)(3) based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for 3 conditions with risk adjusted readmission measures that are endorsed by the National Quality Forum. Directs the Secretary to expand the policy to additional conditions in future years and authorizes the Secretary to modify the adjustment based on a hospital's performance in readmissions compared to a ranking of hospitals nationally. Provides assistance to certain hospitals for transitional care activities to address patient noncompliance issues that may result in high readmission rates. Creates an interim readmissions policy for post-acute providers beginning in FY 2012, and directs the Secretary to develop risk adjusted readmission rates for post-acute providers and implement a readmissions payment system for those providers similar to the hospital system on or after FY 2015. Directs the Secretary to submit a report to Congress no later than one year after date of enactment on how physicians can be incorporated into the readmissions policy. Directs the Secretary to monitor inappropriate changes in admission practices by hospitals and post-acute providers and authorizes the Secretary to penalize providers that are avoiding patients at risk of a readmission.

Sec. 1152. Post acute care (PAC) services payment reform plan. Directs the Secretary to submit to Congress no later than 3 years after date of enactment a detailed plan on how to implement post-acute bundled payments. Converts the existing Acute Care Episode demonstration project to a pilot program and expands the program so that it may include bundling of payments for hospitals and post-acute providers, effective January 1, 2011.

Sec. 1153. Home health payment update for 2010. Provides a freeze in the market basket update for home health agencies for 2010.

Sec. 1154. Payment adjustments for home health care. Accelerates the regulatory adjustment for case mix currently scheduled for 2011 so that it occurs in 2010. Directs the Secretary to rebase the home health prospective payment system for 2011, taking into account changes in the average number and types of visits per episode, change in intensity of visits, and growth in cost per episode.

Sec. 1155. Incorporating productivity improvements into market basket update for home health services. Incorporates a productivity adjustment into the market basket update for home health agencies beginning in 2010. Sets a floor for the home health market basket so that the combination of the productivity adjustment and any adjustments for quality reporting cannot cause the market basket update to go below zero.

Sec. 1155A. MedPAC study on variation in home health margins. Requires MedPAC to undertake a study to examine the variation in Medicare margins among home health agencies. Factors considered will include patient characteristics (including health and socioeconomic factors), agency characteristics, and the types of services provided by different agencies.

Sec. 1155B. Allows home health agencies to assign the most appropriate skilled services to make the initial assessment under a Medicare home health plan of care for rehabilitation cases. Allows home health agencies to assign an occupational therapist to make an initial home assessment if occupational therapy is ordered as part of the referral for home health services.

Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals. Closes a loophole in the self-referral rules that allows physicians to refer patients to hospitals in which they have a direct financial interest. Prohibits physician ownership in hospitals that are new as of January 1, 2009. Grandfathers the ownership structures of all physician-owned hospitals with Medicare provider numbers prior January 1, 2009. Allows for growth of existing physician-owned hospitals within certain parameters.

Sec. 1157. Institute of Medicine Study on Geographic Adjustment Factors Under Medicare. Requires the Secretary to contract with the Institute of Medicine of the National Academies to undertake a study on the validity and effects of the geographic adjusters used for Medicare physician and hospital payments, and to recommend improvements.

Sec. 1158. Revision of Medicare Payment Systems to Address Geographic Inequities. CMS is instructed to respond to recommendations under section 1157 and may spend up to $4 billion per year, for two years, to effect any needed increases in payment rates and to "hold harmless" providers that would otherwise have their payments reduced. Amounts in the Medicare Improvement Fund are reduced to $8 billion, an amount sufficient to fund this section.

Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care. Requires the Secretary to contract with the Institute of Medicine of the National Academies to undertake a study of geographic variation in health care spending among all payers. Factors considered shall include patient demographics and socioeconomic characteristics, health status, the supply of providers of services, input prices, and other factors. The report shall also include recommendations for changes to Medicare payment systems to address such geographic variation and to improve the value of health spending in the program.

Sec. 1160. Implementation, and Congressional Review, of proposal to revise Medicare payments to promote high value health care. The Secretary of HHS is instructed to develop an implementation plan for changing Medicare payment systems, as appropriate, based on recommendations under section 1159. HHS is required to submit the implementation plan to Congress under a schedule that permits ample time to review the report and consider its implications. The plan will be implemented starting in 2013 unless Congress votes to disapprove it.

SUBTITLE D – MEDICARE ADVANTAGE REFORMS

PART 1—Payment and Administration

Sec. 1161. Phase-in of payment based on fee-for-service costs; quality bonus payments. Reduces Medicare Advantage benchmarks to fee-for-service levels over three years, reaching equality of payment rates in 2013. Creates an incentive system to increase payments to high-quality plans in low-cost areas, phased-in over 2011-2013.

Sec. 1162. Extension of Secretarial coding intensity adjustment authority. Extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service.

Sec. 1163. Simplification of annual beneficiary election periods. Provides extra time for CMS and health plans to process enrollment paperwork during annual enrollment periods and eliminates a duplicative open enrollment period for Medicare Advantage plans.

Sec. 1164. Extension of reasonable cost contracts. Extends the period of time for which Cost plans may operate in areas that have other health plan options.

Sec. 1165. Limitation of waiver authority for employer group plans. Restricts the ability of Medicare Advantage plans to offer coverage outside their service area and grandfathers current contracts.

Sec. 1166. Improving risk adjustment for payments. Requires a study on the effectiveness of the Medicare Advantage risk adjustment system for low-income and chronically ill populations.

Sec. 1167. Elimination of MA Regional Plan Stabilization Fund. Eliminates the Medicare Advantage regional plan stabilization fund.

Sec. 1168. Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates. Requires CMS to study the effects of paying Medicare Advantage plans on a more aggregated basis than at the county level.

PART 2 – Beneficiary Protections and Anti-Fraud

Sec. 1171. Limitation on cost-sharing for individual health services. Ensures that beneficiaries in Medicare Advantage plans are not subjected to higher cost-sharing than they would face in fee-for-service Medicare. Ensures that beneficiaries dually eligible for Medicare and Medicaid are not subject to higher cost-sharing than they would face under Medicaid were they not enrolled in Medicare.

Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension. Allows beneficiaries in Medicare Advantage plans facing sanctions for failure to meet program rules to opt out of the plan at any time for another plan or fee-for-service Medicare.

Sec. 1173. Information for beneficiaries on MA plan administrative costs. Requires CMS to publish standardized information on medical loss ratios and other plan information to beneficiaries and the public. For

plans with medical loss ratios below 85%, the provision requires rebates and increasing penalties over time, including eventual termination of contracts.

Sec. 1174. Strengthening audit authority. Strengthens the ability of CMS to recover overpayments to plans discovered by audits.

Sec. 1175. Authority to deny plan bids. Clarifies that CMS is not obligated to accept any or every bid submitted by a Medicare Advantage or Part D plan.

Sec. 1175A. State authority to enforce standardized marketing requirements. Permits states to impose civil monetary penalties and provides for Federal-state coordination of intermediate sanctions against Part D and Medicare Advantage plans found violating marketing rules. Ensures that plans will not face double State and Federal jeopardy for the same violation.

PART 3 – Treatment of Special Needs Plans

Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals. Ensures that chronic condition special needs plans (SNPs) enroll beneficiaries only during the annual election period and special election periods to be determined by CMS.

Sec. 1177. Extension of authority of special needs plans to restrict enrollment. Extends the SNP program through 2012, and extends certain fully integrated dual eligible SNPs through 2015. Also extends the moratorium on service area expansions for dual eligible SNPs that do not meet certain requirements.

Sec. 1178. Extension of Medicare senior housing plans. Extends SNPs that serve residents in continuing care retirement communities.

SUBTITLE E – IMPROVEMENTS TO MEDICARE PART D

Sec. 1181. Elimination of coverage gap. Eliminates Part D donut hole, beginning with a $500 reduction in 2010, and completing phase-out by 2019. Pays for the elimination of the gap with funds raised by requiring drug manufacturers to provide Medicaid rebates for drugs used by full dual eligibles.

Sec. 1182. Discounts for certain Part D drugs in original coverage gap. Incorporates voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs used by Part D enrollees in the Part D donut hole, beginning in 2010.

Sec. 1183. Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities. Eliminates deadlines for long-term care pharmacists to file Part D claims to allow more time for improved coordination with state Medicaid programs.

Sec. 1184. Including costs incurred by AIDS Drug Assistance Programs and Indian Health Service in providing prescription drugs towards the annual out-of-pocket threshold under Part D. Allows drugs provided to patients by AIDS Drug Assistance Programs or the Indian Health Service to count toward out-of-pocket costs, allowing these individuals to qualify for Part D catastrophic benefits.

Sec. 1185. No mid-year formulary changes permitted. Prevents Part D plans from making any formulary change that increase cost-sharing or otherwise reduce coverage once the plan marketing period begins.

Sec. 1186. Negotiation of lower covered Part D drug prices on behalf of Medicare beneficiaries. Requires the Secretary of HHS to negotiate with drug manufacturers for lower Part D drug prices.

Sec. 1187. Accurate dispensing in long-term care facilities. Requires Part D plans to develop utilization management techniques to reduce prescription drug waste in long-term care facilities.

Sec. 1188. Free generic refill. Clarifies that Part D plans may offer generic drugs to enrollees with zero copayment to encourage use of lower-cost generic drugs.

Sec. 1189. State certification prior to waiver of licensure requirements under Medicare prescription drug program. Limits CMS' authority to waive state licensure requirements to situations where the state has certified that the Part D plan's application is substantially complete.

SUBTITLE F—MEDICARE RURAL ACCESS PROTECTIONS

Sec. 1191. Telehealth expansion and enhancements. Streamlines the credentialing process for hospitals and critical access hospitals wishing to use telehealth services. Expands Medicare's telehealth benefit to beneficiaries who are receiving care at freestanding dialysis centers. Also establishes a Telehealth Advisory Committee to provide HHS with additional expertise on the telehealth program.

Sec. 1192. Extension of outpatient hold harmless provision. Extends the existing outpatient hold harmless provision through FY 2011.

Sec. 1193. Extension of section 508 hospital reclassifications. Extends reclassifications under section 508 of the Medicare Modernization Act through FY 2011.

Sec. 1194. Extension of geographic floor for work. Medicare adjusts fees paid for physician services based on geographic variations in costs. Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2011, with the effect of increasing practitioner fees in rural areas.

Sec. 1195. Extension of payment for technical component of certain physician pathology services. Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2011.

Sec. 1196. Extension of ambulance add-ons. Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2011.

TITLE II – MEDICARE BENEFICIARY IMPROVEMENTS

SUBTITLE A – IMPROVING AND SIMPLIFYING FINANCIAL ASSISTANCE FOR LOW INCOME MEDICARE BENEFICIARIES

Sec. 1201. Improving assets tests for Medicare Savings Program and low-income subsidy program. Increases the assets test for eligibility for the Part D low-income subsidy and Medicare Savings Programs to $17,000 for individuals and $34,000 for couples indexed annually by CPI.

Sec. 1202. Elimination of Part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals. Eliminates cost sharing for people receiving care under a home and community based waiver who would otherwise require institutional care.

Sec. 1203. Eliminating barriers to enrollment. Reduces barriers to the low-income subsidy by allowing self-certification and administrative verification of income and data sharing between IRS and SSA.

Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low income subsidy enrollment. Enhances oversight to make sure that low-income beneficiaries who are owed retroactive reimbursement payments from their drug plans receive them.

Sec. 1205. Intelligent assignment in enrollment. Gives CMS authority to use an enrollment process for subsidy-eligible individuals into Part D plans that accounts for the quality, cost and/or formulary of plans.

Sec. 1206. Special enrollment period and automatic enrollment process for certain subsidy eligible individuals. Gives CMS authority to enroll subsidy-eligible beneficiaries into plans using a process that accounts for the quality, cost and/or formulary of plans, while also giving beneficiaries the option of choosing another plan.

Sec. 1207. Application of MA premiums prior to rebate and quality bonus payments in calculation of low income subsidy benchmark. Removes Medicare Advantage rebates and quality bonus payments from the calculation of the low-income subsidy benchmark in order to reduce involuntary switching of full low-income subsidy Part D enrollees.

SUBTITLE B – REDUCING HEALTH DISPARITIES

Sec. 1221. Ensuring effective communication in Medicare. Requires the Secretary of HHS to conduct a study that examines the extent to which Medicare providers utilize, offer or make available language services for beneficiaries who are limited English proficient and ways that Medicare should develop payment systems for language services.

Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services. Instructs the Secretary to carry out a demonstration program to reimburse Medicare providers, in multiple provider settings, for the provision of language services. Requires the Secretary to evaluate the demonstration program and make recommendations on the expansion of such services to the entire Medicare program.

Sec. 1223. IOM Report on impact of language access services. Requires the Secretary to contract with the Institute of Medicine to conduct a study that examines the impact on the quality of care, access to care, the reduction in medical errors and costs or savings associated with the provision of language access services to limited English proficient populations.

Sec. 1224. Definitions. Defines certain terms such as “Competent Interpreter Services”, “Language Services” and “Limited English Proficient” used in Subtitle B.

SUBTITLE C—MISCELLANEOUS IMPROVEMENTS

Sec. 1231. Extension of therapy caps exceptions process. Extends the process allowing exceptions to limitations on medically necessary therapy through 2011.

Sec. 1232. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions. Lifts the current 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2012 and makes technical changes to the bundled payment system for dialysis services.

Sec. 1233. Voluntary advance care planning consultation. Provides coverage for optional consultation between enrollees and practitioners to discuss orders for life-sustaining treatment and other options for advance care planning.

Sec. 1234. Part B special enrollment period and waiver of limited premium enrollment penalty for TRICARE beneficiaries. Provides for a 12-month Medicare Part B special enrollment period for disabled TRICARE beneficiaries and waives increased premium penalties if beneficiaries sign up during such period.

Sec. 1235. Part B Premium Adjusted for Capital Gains. Allows capital gains from the sale of a primary residence to count as a life-changing event for purposes of using a more recent tax year for determination of the Part B income related premium.

Sec. 1236. Demonstration program on use of patient decision aids. Creates a demonstration program that uses decision aids and other technologies to help patients and consumers improve their understanding of the risks and benefits of their treatment options and make informed decisions about their medical care.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

Sec. 1301. Accountable Care Organization pilot program. Creates an alternative payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for the costs and quality of care received by their patient panel over time. Accountable Care Organizations (ACOs) can include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations. ACOs can include nurse practitioners and physician assistants and other providers as designated by the ACO.

ACOs that reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the programmatic savings, conditional on meeting quality targets as well. CMS may allow ACOs to continue operating so long as they are reducing costs while maintaining quality or improving quality while maintaining costs.

Sec. 1302. Medical home pilot program. An expansion and reorientation of the medical home demo in Medicare. Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes. There are two models in the provision: 1) the *independent patient-centered medical home*, structured around a provider, is targeted at the top half of high-need Medicare beneficiaries with multiple chronic diseases, and 2) the *community based medical home*, which may include any eligible beneficiary, is targeted at a broader population of Medicare beneficiaries and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider. Provides approximately $1.8 billion for the pilot programs. The Secretary is authorized to expand the program only if quality measures have been met and budget neutrality is demonstrated.

Sec. 1303. Payment incentive for selected primary care services. Increases the Medicare payment rate by 5% for primary care services of physicians specializing in primary care. Physicians specializing in primary care are defined both by specialty (e.g., family practitioners, internists, and others) and by share of a practice in primary care (at least 50% of allowed charges are for primary care services). Eligible practitioners practicing in health professions shortage areas receive an additional 5%.

Sec. 1304. Increased reimbursement rate for certified nurse-midwives. Increases the payment rate for nurse midwives for covered services from 65% of the rate that would be paid were a physician performing a service to the full rate.

Sec. 1305. Coverage and waiver of cost-sharing for preventive services. Waives all Medicare cost sharing (both co-insurance and deductibles) for preventive services.

Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal. Clarifies that the deductible is waived for a screening colonoscopy even if a diagnosis is established as a result of a test or if tissue is removed during the procedure.

Sec. 1307. Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment. Removes clinical social worker services from coverage under the skilled nursing facility prospective payment system, which allows clinical social workers to bill separately for their services in the skilled nursing facility setting.

Sec. 1308. Coverage of marriage and family therapist services and mental health counselor services. Adds state-licensed or certified marriage and family therapists and mental health counselors as Medicare providers and pays them at the same rate as social workers.

Sec. 1309. Extension of physician fee schedule mental health add-on. Increases the payment rate for psychiatric services by 5% for two years, through the end of 2011.

Sec. 1310. Expanding access to vaccines. Transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines. Vaccines but for influenza will be paid for according to the average sales price methodology.

Sec. 1311. Expansion of Medicare-Covered Preventive Services at Federally Qualified Health Centers. Expands Medicare reimbursements for preventive services furnished by federally qualified health centers.

Sec. 1312. Independence at Home Demonstration Program. Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

Sec. 1313. Recognition of certified diabetes providers for purposes of Medicare diabetes outpatient self-management training services. Allows certified diabetes educators to receive payment from Medicare directly for the provision of outpatient self-management training services.

TITLE IV—QUALITY

SUBTITLE A—COMPARATIVE EFFECTIVENESS RESEARCH

Sec. 1401. Comparative Effectiveness Research (CER). Creates a new Center at the Agency for Healthcare Research and Quality, supported by a combination of public and private funding that will conduct, support and synthesize CER. Establishes an independent stakeholder commission which recommends to the Center research priorities, study methods, and ways to disseminate research. The commission would have its own source of funding and also be responsible for evaluating the processes of the center and authorized to make reports directly to Congress. A majority of the Commission members would be required to be physicians, other health care practitioners, consumers or patients. Contains protections to ensure that subpopulations are appropriately accounted for in research study design and dissemination; protections to prevent the Center and Commission from mandating payment, coverage or reimbursement policies.; protections to ensure that research findings are not construed to mandate coverage, reimbursement or other policies to any public or private payer, and clarify that federal officers and employees will not interfere in the practice of medicine.

SUBTITLE B -- NURSING HOME TRANSPARENCY

PART 1 - Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities

Sec. 1411. Required disclosure of ownership and additional disclosable parties information. Requires skilled nursing facilities (SNFs) and nursing facilities (NFs) to disclose information on ownership and facility organizational structure and requires the Secretary to develop a standardized format for such information within two years of date of enactment.

Sec. 1412. Accountability Requirements. Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011.

Sec. 1413. Nursing home compare Medicare website. Directs the Secretary to include additional information on the Nursing Home Compare website, include staffing data based on information collected under section 1416 and summary information on complaints filed for SNFs and NFs.

Sec. 1414. Reporting of expenditures. Requires SNFs to separately report expenditures for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after date of enactment.

Sec. 1415. Standardized complaint form. Directs the Secretary to create a standardized complaint form and requires states to establish complain resolution processes. Provides whistleblower protection for employees who complain in good faith about the quality of care or services at a facility.

Sec. 1416. Ensuring staffing accountability. Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, including information on agency or contract staff. Effective two years after date of enactment.

Sec. 1417. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers. Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees.

PART 2 – Targeting Enforcement

Sec. 1421. Civil money penalties. Authorizes the Secretary to impose civil monetary penalties for a deficiency that results in the direct proximate cause of death of a resident. Provides additional authority to the Secretary to raise or adjust CMPs under certain circumstances.

Sec. 1422. National independent monitor pilot program. Directs the Secretary to establish, in consultation with the HHS Inspector General, a pilot program to develop, test and implement use of an independent monitor to oversee interstate and large intrastate chains of SNFs and NFs.

Sec. 1423. Notification of facility closure. Requires the administrator of a facility that is preparing to close to provide written notification to residents and other parties and to prepare a plan for closing that ensure safe transfer of residents to new facilities.

PART 3 – Improving Staff Training

Sec. 1431. Dementia and abuse prevention training. Requires SNFs and NFs to conduct dementia management and abuse prevention training prior to employment and, if the Secretary determines appropriate, as part of ongoing training.

Sec. 1432. Study and report on training required for certified nurse aides and supervisory staff. Requires the Secretary to study the content of training requirements for certified nurse aids and supervisory staff of SNFs and NFs and to submit a report with recommendations on content and length of training to Congress within two years of date of enactment.

Sec. 1433. Qualification of a director of food services of a skilled nursing facility or a nursing facility. Requires that full-time directors of food services shall be a Certified Dietary Manager, Dietetic Technician, or have equivalent military, academic, or other qualifications as specified by the Secretary.

SUBTITLE C—QUALITY MEASUREMENTS

Sec. 1441. Establishment of national priorities for quality improvement. Directs the Secretary to establish national priorities for performance improvement, incorporating recommendations from outside entities. These priorities should reflect areas that contribute to a large burden of disease, have high potential to decrease morbidity and mortality and improve performance, address health disparities, and have the potential to produce the most rapid change based on current evidence.

Sec. 1442. Development of new quality measures; GAO evaluation of data collection process for quality measurement. Based on the national priorities for performance improvement established in this part, the Secretary shall develop, test and update new patient-centered and population-based quality measures for the assessment of health care services. Provides $25 million for this section. Instructs GAO to periodically evaluate the program to determine the effectiveness of the quality measures and the extent to which these measures can result in quality improvement and cost savings, and report to Congress.

Sec. 1443. Multi-stakeholder pre-rulemaking input into selection of quality measures. Provides for stakeholder input into the use of quality measures for purposes of payment. Each year, the Secretary shall make public a list of measures being considered for usage for payment systems. Under a transparent process, a consensus-based entity shall convene a multi-stakeholder group to provide recommendations for the usage of measures in a timely fashion, and the Secretary shall consider these recommendations.

Sec. 1444. Application of quality measures. Ensures that quality measures selected by the Secretary are endorsed by a consensus-based entity with a contract with the Secretary under section 1890, except in certain circumstances, e.g., the measure has not been evaluated and no comparable endorsed measure exists. If the Secretary chooses to use a measure that the entity considers but does not endorse, the Secretary shall include the rationale for continued use in rulemaking. Applies this standard to inpatient hospitals, physician services, and renal dialysis services.

Sec. 1445. Consensus-based entity funding. For the consensus based entity with a contract under section 1890, the contract amount is increased to $12 million for the years 2010-2012.

SUBTITLE D—PHYSICIAN PAYMENTS SUNSHINE PROVISION

Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities. Requires manufacturers or distributors to electronically report to the HHS OIG any payments or other transfers of value above a $5 de minimis made to a "covered recipient" and requires hospitals, manufacturers, distributors, and group purchasing organizations to report any ownership share by a physician. Failure to report is subject to civil monetary penalties from $1000 to $10,000 (max $150,000 per year) per payment, transfer of value, or investment interest not disclosed; penalties for knowing failure to report range from $10,000 to $100,000 per payment, not to exceed $1,000,000 in one year or .1% of revenues for that year.

SUBTITLE E – PUBLIC REPORTING ON HEALTHCARE-ASSOCIATED INFECTIONS

Sec. 1461. Requirement for public reporting by hospitals and ambulatory surgical centers on healthcare-associated infections. Requires hospitals and ambulatory surgical centers to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

Sec. 1501. Distribution of unused residency positions. Directs the Secretary to redistribute residency positions that have been unfilled for the prior 3 cost reports and direct those slots for training of primary care physicians. Special preference will be given to programs that saw a reduction in their slots under this section, have formal arrangements to train residents in ambulatory settings or shortage areas, operate three-year primary care residency programs, currently operate residency programs over their cap, or are located in states with a low physician resident to general population ratio.

Sec. 1502. Increasing training in nonprovider settings. Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits. Directs the HHS Office of the Inspector General to study the level of training in non-provider settings. Establishes a demonstration project whereby approved teaching health centers (which may be non-provider settings such as rural health clinics and federally qualified health centers) may become a primary care training program and receive DGME and the DGME of its contracting hospitals for such residents.

Sec. 1503. Rules for counting resident time for didactic and scholarly activities and other activities. Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting and toward DGME in the non-provider (i.e., non-hospital) setting.

Sec. 1504. Preservation of resident cap positions from closed hospitals. Directs the Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is 2 years before the enactment of this clause to other hospitals in the same State, taking into account recommendations by the senior health official in the State. Such recommendations shall be submitted not later than 180 days after the date of the hospital closure involved, or in the case of a hospital that closed within two years of date of enactment, not later than 180 days after enactment.

Sec. 1505. Improving accountability for approved medical residency training. Sets goals for approved medical residency training programs by setting broad goal that include: (1) training to work in non-acute traditional settings; (2) coordination of care within and across settings; (3) understanding cost and value of diagnostic and treatment options; (4) working in multi-disciplinary teams; (5) participating in quality improvement projects; and, (6) demonstrating meaningful use of electronic health records in improving quality of patient care. Directs the GAO to evaluate the extent to which residency training programs are meeting the goals cited.

TITLE VI—PROGRAM INTEGRITY

SUBTITLE A—INCREASED FUNDING TO FIGHT WASTE, FRAUD, AND ABUSE

Sec. 1601. Increased funding and flexibility to fight fraud and abuse. Provides an additional $100 million annually in funding for the Health Care Fraud and Abuse Control Fund. Allows expanded use of funds by the CMS Medicare Integrity Program.

SUBTITLE B—ENHANCED PENALTIES FOR FRAUD AND ABUSE

Sec. 1611. Enhanced penalties for false statements on provider or supplier enrollment applications. Establishes civil monetary penalties of $50,000 per violation for providers, suppliers, Medicare Advantage, or Part D plans that knowingly make false statements or misrepresentation of material fact on enrollment applications for any federal health care program.

Sec. 1612. Enhanced penalties for submission of false statements material to a false claim. Establishes civil monetary penalties of $50,000 per violation for the knowing submission of false statements or misrepresentation of material fact in information submitted to support a claim for payment.

Sec. 1613. Enhanced penalties for delaying inspections. Establishes civil monetary penalties of $15,000 per day for delaying or refusing to grant timely access to the HHS OIG for audits, investigations, or evaluations.

Sec. 1614. Enhanced hospice program safeguards. Requires the Secretary to take immediate action to remedy any violation in a hospice facility that jeopardizes the health and safety of patients. Allows intermediate sanctions such as civil monetary penalties, suspension or partial payments, appointment of temporary management to oversee operation, plans of correction, or in-service staff training, for violations that do not endanger patients.

Sec. 1615. Enhanced penalties for individuals excluded from program participation. Establishes civil monetary penalties of $50,000 per violation for any person who orders or prescribes an item or service while excluded from a federal health care program if that person knows or should know that the program from which they are excluded will be billed for the item or service.

Sec. 1616. Enhanced penalties for provision of false information by Medicare Advantage and Part D plans. Establishes civil monetary penalties for misrepresentations or false information provided by an MA or Part D plan of up to three times the payment made to the plan or plan sponsor based on the misrepresentation or false information.

Sec. 1617. Enhanced penalties for Medicare Advantage and Part D marketing violations. Establishes new criteria for determining marketing violations, and provides greater discretion to the Secretary or the CMS Administrator to impose penalties on Medicare Advantage and Part D plans that violate marketing requirements.

Sec. 1618. Enhanced penalties for obstruction of program audits. Allows for permissive exclusion of individuals or entities found to have obstructed an investigation into or audit of fraud.

Sec. 1619. Exclusion of certain individuals and entities from participation in Medicare and State Health Care Programs. Clarifies definition of exclusion of Medicare and Medicaid entities under section 1128 to mean exclusion from all federal health care programs.

Sec. 1620. OIG authority to exclude from Federal health care programs officers and owners of entities convicted of fraud. Clarifies OIG authority to exclude from Federal health care programs individuals who knew or should have known of violations at the time these violations occurred.

Sec. 1621. Self-referral voluntary disclosure protocol. Requires HHS Secretary to establish a protocol to allow health care providers and suppliers to voluntarily disclose an actual or potential violation of the Social Security Act's provisions against self-referrals.

SUBTITLE C – ENHANCED PROGRAM AND PROVIDER PROTECTIONS

Sec. 1631. Enhanced CMS program protection authority. Allows the Secretary to designate program areas of "significant risk" in which enhanced oversight can be applied to prohibit waste, fraud, and abuse. Calls for the Secretary to establish screening procedures for new providers, which may include: licensing board checks,

screening lists of those excluded from other federal or state health programs, background checks, unannounced pre-enrollment or other site visits. Allows for enhanced oversight periods (to include site visits, prepayment review, enhanced claims review) for new providers or suppliers in these areas of high risk, and allows for a moratorium on enrollment of new suppliers or service providers in areas of high risk if the Secretary determines that there would be no adverse impact on beneficiaries.

Sec. 1632. Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations. Requires new suppliers or providers of services to disclose affiliations within the past 10 years with any provider or supplier that has uncollected debt or has been suspended from Medicare, Medicaid, or CHIP.

Sec. 1633. Required inclusion of payment modifier for certain evaluation and management services. Establishes a "payment modifier" when service results in ordering additional services, prescription drugs, or durable medical equipment, in order to assist efforts to identify fraud.

Sec. 1634. Required evaluations and reports under Medicare Integrity Program. Requires MIP contractors to conduct periodic evaluations and report on the effectiveness of their activities.

Sec. 1635. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse. Requires all providers and suppliers (other than physicians) to adopt compliance programs and authorizes the Secretary to disenroll a supplier or impose civil monetary penalties or other intermediate sanctions for failure to establish such a program.

Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months. Reduces the period for Medicare claims submission in order to reduce "gaming" of payment systems.

Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals. Requires that physicians ordering durable medical equipment or home health services billable to Medicare must be Medicare-enrolled physicians or eligible professionals. Allows the Secretary discretion to expand this requirement to other areas if such an extension would help reduce waste, fraud, and abuse.

Sec. 1638. Require physicians to provide documentation on referrals to programs at high risk of waste and abuse. Requires physician or supplier to maintain and provide upon request of the Secretary, documentation related to the ordering of durable medical equipment, home health services, or other areas of high risk.

Sec. 1639. Required face to face encounter with patient before physicians may certify eligibility for home health services or durable medical equipment under Medicare. Requires a face-to-face (or telemedicine) encounter with a patient before a physician may certify home health services or durable medical equipment. Allows the Secretary discretion to expand this requirement to other areas if such an extension would help reduce waste, fraud, and abuse.

Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations. Clarifies that the Secretary (or designee) may subpoena documents or testimony for purposes of a program exclusion investigation.

Sec. 1641. Required repayments of Medicare and Medicaid overpayments. Clarifies that when a provider or supplier, MA or Part D plan (but not a beneficiary) becomes aware of a Medicare or Medicaid overpayment, it must be reported and returned within 60 days.

Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program. Clarifies that the hardship waiver provision applies to "beneficiaries," as defined elsewhere in the title.

Sec. 1643. Access to certain information on renal dialysis facilities. Provides authority for the OIG to access ownership or compensation agreements between renal dialysis facilities and physicians.

Section 1644. Billing agents, clearinghouses, or other alternate payees required to register under Medicare and Medicaid. Requires billing agents, clearinghouses, or other alternate payees required to be registered under Medicare and Medicaid in a form and manner to be specified by the Secretary.

Section 1645. Conforming civil monetary penalties to False Claims Act amendments. Conforms key definitions and criteria regarding civil monetary penalty authority under the Social Security Act to match those contained in the 2009 False Claims Act amendments.

Sec. 1646. Require provider and supplier payments under Medicare to be made through direct deposit or electronic funds transfer (EFT) at insured depository institutions. Requires that as of July 1, 2012, all Medicare payments to providers of services and suppliers be made through direct deposit or electronic funds transfer.

Sec. 1647. Inspector General for the Health Choices Administration. Established the Office of the Inspector General for the Health Choices Administration, authorizing the IG to conduct, supervise, and coordinate audits, evaluations, and investigations of the Exchange and other programs and operations of the Health Choices Administration.

SUBTITLE D – ACCESS TO INFORMATION NEEDED TO PREVENT FRAUD, WASTE AND ABUSE

Sec. 1651. Access to information necessary to identify fraud, waste, and abuse. Clarifies that the Department of Justice, working with OIG in consultation with CMS, has access to Medicare and Medicaid claims and payment databases, in a manner that complies with privacy and security laws, including HIPAA.

Sec. 1652. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank. Directs the Secretary to reduce duplication between the two databases. Allows access to the National Practitioner Databank by the VA.

Sec. 1653. Compliance with HIPAA privacy and security standards. Clarifies that HIPAA applies to the subtitle and all amendments.

TITLE VII—MEDICAID AND CHIP

SUBTITLE A—MEDICAID AND HEALTH REFORM

Sec. 1701. Eligibility for individuals with income below 150 percent of the Federal poverty level.
(a) Requires State Medicaid programs to cover non-disabled, childless adults under age 65 not eligible for Medicare with incomes at or below 150% of FPL ($16,200 per year for an individual). The federal government would pay 100% of the costs of Medicaid coverage for this population in 2013 and 2014, then 91% in 2015 and beyond.
(b) Requires State Medicaid programs to cover children, parents, and individuals with disabilities under age 65 with income at or below 150% of FPL ($33,100 per year for a family of 4). For individuals in these categories with incomes between the levels in effect in the state as of June 16, 2009 and 150% of FPL, the federal government would pay 100% of the costs of Medicaid coverage in 2013 and 2014 and 91% in 2015 and beyond.
(c) Requires State Medicaid programs to cover newborns up to the first 60 days of life who do not otherwise have coverage upon birth. The federal government would pay 100% of the costs of Medicaid coverage for these newborns.

Sec. 1702. Requirements and special rules for certain Medicaid eligible individuals. Requires State Medicaid programs to enter into a memorandum of understanding with the Health Choices Commissioner to coordinate enrollment of low-income individuals, including newborns, into the Exchange or Medicaid as appropriate.

Sec. 1703. CHIP and Medicaid maintenance of eligibility.
(a) Prohibits States from adopting eligibility standards, methodologies, or procedures in their CHIP programs that are more restrictive than those in effect as of June 16, 2009. Maintenance of eligibility ends upon expiration of CHIP program on December 31, 2013.
(b) Prohibits States from adopting eligibility standards, methodologies, or procedures in their Medicaid programs more restrictive than those in effect as of June 16, 2009.

Sec. 1704. Reduction in Medicaid DSH. Requires the Secretary of HHS to report to Congress by January 1, 2016 on the continuing role of Medicaid DSH as health reform is implemented. Directs the Secretary to reduce federal Medicaid DSH matching payments to States by a total of $10 billion ($1.5 billion in FY 2017, $2.5 billion in FY 2018, and $6.0 billion in FY 2019) using a methodology that focuses on the percentage of uninsured and the amount of uncompensated care provided by hospitals in each State.

Sec. 1705. Expanded outstationing. Requires State Medicaid programs to allow all individuals to apply for coverage in Medicaid at DSH hospitals, FQHCs, and other locations than welfare offices. Extends requirement to applications for coverage in the Exchange beginning in 2013.

SUBTITLE B — PREVENTION

Sec. 1711. Required coverage of preventive services. Requires State Medicaid programs to cover, without cost-sharing,, preventive services that are recommended by the U.S. Preventive Services Task Force and appropriate for Medicaid beneficiaries.

Sec. 1712. Tobacco cessation. Prohibits State Medicaid programs from excluding tobacco cessation products from coverage.

Sec. 1713. Optional coverage of nurse home visitation services. Allows State Medicaid programs to cover home visits by trained nurses to families with a first-time pregnant woman or child under 2 eligible for Medicaid.

Sec. 1714. State eligibility option for family planning services. Allows State Medicaid programs to cover low-income women who are not pregnant for family planning services and supplies without obtaining a waiver. Allows State Medicaid programs to cover such services for such women during a presumptive eligibility period.

SUBTITLE C — ACCESS

Sec. 1721. Payments to primary care practitioners. Requires that State Medicaid programs reimburse for primary care services furnished by physicians and other practitioners at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and after. Maintains the Medicare payment differentials between physicians and other practitioners. The federal government would pay 100% of the incremental costs attributable to this requirement through 2014, then 90% in 2015 and beyond.

Sec. 1722. Medical home pilot program. Establishes a 5-year pilot program to test the medical home concept with Medicaid beneficiaries including medically fragile children and high-risk pregnant women. The federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of $1.235 billion.

Sec. 1723. Translation or interpretation services. Provides a 75 % federal matching rate for the costs of translation or interpretation services for Medicaid-eligible adults for whom English is not the primary language.

Sec. 1724. Optional coverage for freestanding birth center services. Allows State Medicaid programs to cover services provided by birth centers that are not hospitals.

Sec. 1725. Inclusion of public health clinics under the vaccines for children program. Allows children who do not have insurance coverage for immunizations to receive vaccines through the VFC program at a public health clinic.

Sec. 1726. Requiring coverage of services of podiatrists. Requires State Medicaid programs to cover physician's services when furnished by a podiatrist.

Sec. 1726A. Requiring coverage of services of optometrists. Requires State Medicaid programs to cover services furnished by optometrists to the extent permitted under state law.

Sec. 1727. Therapeutic foster care. Clarifies that federal Medicaid law does not prohibit State Medicaid programs from covering therapeutic foster care for children in out-of-home placements.

Sec. 1728. Assuring adequate payment levels for services. Requires State Medicaid programs to submit annually to the Secretary payment rates to be used to reimburse providers for furnishing covered services and directs the Secretary to review such rates for sufficiency.

Sec. 1729. Preserving Medicaid coverage for youths upon release from public institutions. Requires State Medicaid programs to suspend, not terminate, eligibility for beneficiaries under age 19 who are incarcerated in a public institution during the period of incarceration.

Sec. 1730. Quality measures for maternity and adult health services under Medicaid and CHIP. Appropriates $40 million for 2010-2015 for the Secretary to develop a set of measures for the quality of maternity care and other adult care provided under Medicaid and CHIP, and to develop a standardized format for reporting such quality measures for use by the states.

Sec. 1730A. Accountable care organization pilot program. Directs the Secretary to establish a program to allow State Medicaid programs to pilot one or more of the models used in the Medicare ACO pilot program established by section 1301 of the bill. Administrative costs would be matched at 90% in the first two years of a pilot project, 75% in the last three.

Sec. 1730B. Coverage of School-based health clinics. Requires that State Medicaid programs reimburse school-based health clinics receiving funds under the program established by section 2511 on the same basis as they reimburse federally-qualified health centers (FQHCs).

SUBTITLE D – COVERAGE

Sec. 1731. Optional Medicaid coverage of low-income HIV-infected individuals. Allows State Medicaid programs to cover individuals with HIV with incomes and resources below state eligibility levels for individuals with disabilities. The costs of coverage of such individuals would be matched at an enhanced rate. Effective on enactment. Sunsets on January 1, 2013.

Sec. 1732. Extending transitional Medicaid Assistance (TMA). Extends the 1-year transitional Medicaid coverage for families leaving cash assistance to work from December 31, 2010 through December 31, 2012.

Sec. 1733. Requirement of 12-month continuous coverage under certain CHIP programs. Requires stand-alone CHIP programs to provide 12-month continuous eligibility for all enrollees with incomes below 200% FPL. Effective January 1, 2010.

Sec. 1734. Preventing the application under CHIP of coverage waiting periods for certain children. Prohibits State CHIP programs from imposing eligibility waiting periods on children who are (1) under age 2, (2) in families losing private health insurance due to unemployment, or (3) in families that pay more than 10 percent of income for health insurance coverage.

Sec. 1735. Adult day health care services. Prohibits the Secretary from denying federal Medicaid matching funds to certain States for the cost of adult day health care services.

Sec. 1736. Medicaid coverage for citizens of Freely Associated States. Requires State Medicaid programs to cover citizens of Micronesia, the Marshall Islands, or Palau who are lawfully residing in the State (under the compact of Free Association) and otherwise eligible for Medicaid there.

Sec. 1737. Continuing requirement of Medicaid coverage of nonemergency transportation to medically necessary services. Requires State Medicaid programs to continue covering nonemergency transportation to medically necessary services as specified in regulations in effect on June 1, 2008.

Sec. 1738. State option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high prescription costs. Allows State Medicaid programs to cover individuals with family incomes up to $150,000 who have orphan drug costs exceeding $200,000 and have exhausted their private health insurance coverage for prescription drugs.

Sec. 1739. Provisions relating to community living assistance services and supports (CLASS). Requires States to comply with primary and secondary payor rules established by the Secretary with respect to the CLASS program under section 2581. Also requires States to designate or create fiscal agents for personal care attendant workers serving CLASS program beneficiaries.

SUBTITLE E – FINANCING

Sec. 1741. Payments to pharmacists. Extends current rules for Medicaid payments to pharmacists for multiple source drugs through December 31, 2010. Thereafter, limits Medicaid payments for such drugs to 130% of the weighted average manufacturer price (AMP). Redefines AMP to exclude certain price concessions, including those provided to pharmacy benefit managers, not passed through to retail pharmacies.

Sec. 1742. Prescription drug rebates. Increases the minimum manufacturer rebate for brand-name drugs purchased by State Medicaid programs from 15.1% of average manufacturer price to 22.1% of average manufacturer price, and applies the additional Medicaid rebate to new formulations of brand-name drugs. Effective January 1, 2010.

Sec. 1743. Extension of prescription drug discounts to enrollees of Medicaid managed care organizations. Requires manufacturers to pay rebates to State Medicaid programs for drugs dispensed to program beneficiaries enrolled in Medicaid managed care organizations. Effective July 1, 2010.

Sec. 1744. Payments for graduate medical education. Clarifies that State Medicaid programs may receive federal matching payments for the costs of graduate medical education. Directs the Secretary to specify program goals for the use of such funds based on workforce needs. Effective upon enactment.

Sec. 1745. Temporary Nursing Facility Supplemental Payment Program. Establishes a temporary 4-year program of supplemental payments directly from the Centers for Medicare & Medicaid Services to nursing

facilities with high percentages of Medicare and Medicaid patient days to assist them in meeting the costs of care to Medicaid beneficiaries. A total of $6 billion would be available for such payments over the period 2010 through 2013. The Medicaid and CHIP Payment Advisory Committee (MACPAC) would be required to study the adequacy of payment rates to nursing facilities in each State and report to Congress by December 31, 2011.

Sec. 1746. Report on Medicaid payments. Requires State Medicaid programs to submit annually to the Centers for Medicare & Medicaid Services information on the determination of rates of payment to providers for covered services.

Sec. 1747. Reviews of Medicaid. Directs GAO to study and report to Congress by February 15, 2011, on (1) the federal Medicaid matching rate formula and (2) the use of federal Medicaid funds on administrative expenditures and the process for determining those rates.

Sec. 1748. Extension of delay in managed care organization provider tax elimination. Extends to October 1, 2010, the grace period for the use of revenues from taxes imposed on Medicaid managed care organizations as state share for Medicaid matching purposes.

SUBTITLE F – WASTE, FRAUD, AND ABUSE

Sec. 1751. Health-care acquired conditions. Prohibits federal matching payments for the cost of health care acquired conditions that are determined to be non-covered services for Medicare purposes.

Sec. 1752. Evaluations and reports required under Medicaid Integrity Program. Requires Medicaid Integrity Program contractors to submit to the Secretary an annual report on integrity activities.

Sec. 1753. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse. Requires providers and suppliers participating in Medicaid (other than physicians and nursing facilities) to establish compliance programs.

Sec. 1754. Overpayments. Allows State Medicaid programs up to 1 year to return the federal share of overpayments to providers due to fraud.

Sec. 1755. Managed Care Organizations. Limits spending by Medicaid managed care organizations on administration, marketing, and distributions to shareholders to no more than 15% of Medicaid premium revenues.

Sec. 1756. Termination of provider participation under Medicaid and CHIP if terminated under Medicare or other State plan or child health plan. Requires State Medicaid and CHIP programs to terminate the participation of entities or individuals if the entity or individual is terminated under Medicare, any other state Medicaid program, or any other CHIP program.

Sec. 1757. Medicaid and CHIP exclusion from participation relating to certain ownership, control, and management affiliations. Requires State Medicaid and CHIP programs to exclude individuals or entities from participation if the individual or entity owns, controls, or manages an entity has unpaid overpayments or is suspended or excluded from participation.

Sec. 1758. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse. Requires State Medicaid programs to include in their Medicaid Management Information Systems (MMIS) reports to the Secretary data elements necessary for the detection of waste, fraud, and abuse.

Sec. 1759. Registration of alternate payees. Requires agents, clearinghouses, or other alternate payees that submit claims on behalf of a health care provider to register with the State and the Secretary. Denies payment for any claims submitted by an unregistered alternate payee.

Sec. 1760. Denial of payments for litigation-related misconduct. Prohibits federal matching payments for costs in litigation costs in which a court imposes sanctions for litigation-related misconduct.

Sec. 1761. Mandatory State use of national correct coding initiative. Requires State Medicaid programs to use methodologies specified by the Secretary to control incorrect coding of claims that lead to improper payment.

SUBTITLE G – PAYMENTS TO THE TERRITORIES

Sec.1771. Payments to the Territories. Raises the federal matching rate for all territories to the highest rate for any state and increases the ceilings on federal matching payments to each territory by specified amounts within an overall increase of totaling $10.350 billion over the period 2011 through 2019.

SUBTITLE H —MISCELLANEOUS

Sec.1781. Technical corrections. Makes technical corrections relating to the administration of the low-income subsidy program under Medicaid Part D, CHIPRA, and sections 1905 and 1115 of the Social Security Act.

Sec. 1782. Extension of QI program. Eliminates the funding limitation and extends for two years (through December 2012) the qualified individuals program to assist low-income Medicare beneficiaries with paying Medicare premiums.

Sec. 1783. Assuring transparency of information. Requires States, as a condition of receiving federal Medicaid matching funds, to establish and maintain laws to require disclosure of information on hospital charges and quality and to make such information public.

Sec. 1784. Medicaid and CHIP Payment and Access Commission. Provides start-up funds for the Medicaid and CHIP Payment and Access Commission and directs the Commission to study State Medicaid payment policies vis-à-vis nursing facilities and pediatric subspecialists.

Sec. 1785. Outreach and enrollment of Medicaid and CHIP eligible individuals. Directs the Secretary to issue guidance regarding outreach and enrollment for Medicaid and CHIP targeted to vulnerable populations such as homeless youth and individuals with HIV/AIDS.

Sec. 1786. Prohibitions on Federal Medicaid and CHIP payment for undocumented aliens. Clarifies that this bill does not change current prohibitions against federal Medicaid and CHIP payments on behalf of individuals who are not lawfully present in the U.S.

Sec. 1787. Demonstration project for stabilization of emergency medical conditions by nonpublicly owned or operated institutions for mental diseases. Provides $75 million for a 3-year demonstration project to test the reimbursement of private psychiatric hospitals for the stabilization of individuals between 21 and 65 with emergency medical conditions.

Sec. 1788. Application of Medicaid Improvement Fund. Applies amounts in the Medicaid Improvement Fund to offset the costs of this bill for fiscal years 2014 through 2018.

Sec. 1789. Treatment of certain Medicaid brokers. Exempts enrollment brokers from certain requirements of the Medicaid statute if the Inspector General finds that the broker has procedures to ensure the independence of its enrollment activities from conflicts of interest.

Sec. 1790. Rule for changes requiring State legislation. Provides a grace period for States that need legislative action in order to comply with a requirement of the bill.

TITLE VIII – REVENUE-RELATED PROVISIONS

Sec. 1801. Disclosures to facilitate identification of individuals likely to be ineligible for the low-income assistance under the Medicare prescription drug program to assist Social Security Administration's outreach to eligible individuals. Authorizes the IRS to disclose to SSA certain taxpayer return information to assist SSA in its outreach program to identify individuals who are eligible for Medicare Part D assistance.

Sec. 1802. Comparative Effectiveness Research Trust Fund (CERTF); financing for Trust Fund. Establishes the trust fund for the comparative effectiveness research program with dedicated amounts going to both the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission. Also establishes a fee that is assessed on private insurance on the basis of the number of insured individuals to fund the research program, provides for transfers from the Medicare trust funds to the CERTF in addition to the fee.

TITLE IX – MISCELLANEOUS PROVISIONS

Sec. 1901. Repeal of trigger provision. Repeals Subtitle A of Title VIII of the Medicare Prescription Drug, Improvement and Modernization act, commonly referred to as the "45% trigger".

Sec. 1902. Repeal of comparative cost adjustment (CCA) program. Repeals section 1860-1 of the Social Security Act, as added by section 241(a) of the Medicare, Prescription Drug, Improvement and Modernization Act of 2003, commonly referred to as the "premium support demonstration project."

Sec. 1903. Extension of gainsharing demonstration. Extends Gainsharing Demonstration of the Deficit Reduction Act of 2005 from December 31, 2009 to September 30, 2011.

Sec. 1904. Grants to States for quality home visitation programs for families with young children and families expecting children. Provides grants to States to support voluntary, evidence-based home visitation programs for pregnant women and for families with pre-school age children in order to improve the well-being, health and development of children.

Sec. 1905. Improved coordination and protection for dual eligibles. Requires CMS to establish a dedicated office or program to improve coordination of benefits and other policies for beneficiaries dually eligible for Medicare and Medicaid.

Sec. 1906. Assessment of Medicare cost-intensive diseases and conditions. Directs the Secretary to consult with relevant research agencies and conduct an assessment of the diseases and conditions that are or could become most cost-intensive for the Medicare program. Directs the Secretary to assess whether current research priorities are appropriately addressing such conditions and make funding recommendations concerning research that should be funded to improve the prevention, treatment or cure of such conditions. Directs the Secretary to biennially review and update the assessment are submit a report on that assessment to Congress.

Sec. 1907. Establishment of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicaid and Medicaid Services a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded within both programs.

Sec. 1908. Application of emergency services laws. Clarifies that nothing in this Act shall be construed to relieve any health care provider from the requirement to provide emergency services according to any State or Federal law, including EMTALA.

Sec. 1909. Disregard under the Supplemental Security Income program of compensation for participation in clinical trials for rare diseases or conditions. Disregards from income up to the first $2,000 per year received for participation in a paid clinical trial by a Supplemental Social Security Income (SSI) recipient with a rare disease or condition.

DIVISION C – PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

Sec. 2201. Table of Contents; references.

Sec. 2002. Public health investment fund. Establishes the Public Health Investment Fund and deposits a total of $34 billion for use over the next five years (FY 2011 – FY 2015). These funds are authorized to be appropriated by the Committee on Appropriations for activities in this Division (described below) and are over and above the level of appropriations provided for these activities for FY 2008.

Sec. 2003. Deficit neutrality. Establishes that funds are available only for the purposes described in Division C. Requires, for estimation purposes, that funds be treated as direct spending, that they be attributed to this Act and that future appropriations be included in the list of mandatory appropriations.

TITLE I – COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding. Authorizes an additional $12 billion over the next five years (FY 2011 – FY 2015) for community health centers to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

TITLE II – WORKFORCE

SUBTITLE A – PRIMARY CARE WORKFORCE

PART 1 – National Health Service Corps

Sec. 2201. National Health Service Corps. Increases loan repayment benefits for each Corps member to a maximum of $50,000 per year. Allows fulfillment of Corps service obligation through part-time service as well as through clinical teaching (for up to 20% of the period of obligated service).

Sec. 2202. Authorization of appropriations. Authorizes an additional $1.8 billion over the next five years (FY 2011 – FY 2015) for the National Health Service Corps to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such sums are over and above the level of appropriations provided for FY 2008.)

PART 2 – Promotion of Primary Care and Dentistry

Sec. 2211. Frontline Health Providers. Establishes a loan repayment program to address health care needs in geographic areas ("health professional needs areas") not currently recognized as health professional shortage areas. Eligible providers include those who qualify to participate in the National Health Service Corps as well as other categories of physicians and health professionals.

Sec. 2212. Primary care student loan funds. Revises current guidelines pertaining to the submission of financial information of a student's family for the purpose of determining the financial resources available to the

student to support his/her health profession education. Requires the Secretary to take into account the extent to which an individual is financially independent in determining whether to require or authorize the submission of financial information of the individual's family members.

Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistants. Provides funding to support primary care training programs and to build academic capacity in primary care.

Sec. 2214. Training of medical residents in community-based settings. Establishes a program to provide support for the development and operation of training programs for medical residents in community-based settings such as community health centers.

Sec. 2215. Training for general, pediatric, and public health dentists and dental hygienists. Provides funding to support training programs for general, pediatric, and public health dentists and dental hygienists, including faculty loan repayment benefits.

Sec. 2216. Authorization of appropriations. Authorizes an additional $1.3 billion over the next five years (FY 2011 – FY 2015) for various primary care programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

Sec. 2217. Study on effectiveness of scholarships and loan repayments. Requires GAO to conduct a study on the effectiveness of scholarships and loan repayments offered through both the National Health Service Corps and the Frontline Health Provider Program in encouraging individuals to pursue and maintain careers in primary care and to practice in underserved areas.

SUBTITLE B – NURSING WORKFORCE

Sec. 2221. Amendments to Public Health Service Act. Makes a number of improvements in nursing programs, including increasing loan repayment benefits for nursing students and faculty; removing the cap on awards for nursing students pursuing a doctoral degree; and clarifying that nurse-managed health centers are eligible for grant awards. Authorizes an additional $638 million over the next five years (FY 2011 – FY 2015) for various nursing programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

SUBTITLE C – PUBLIC HEALTH WORKFORCE

Sec. 2231. Public Health Workforce Corps. Establishes a Public Health Workforce Corps to address public health workforce shortages. Modeled on the National Health Service Corps, the program provides scholarship and loan repayment support for public health professionals serving in areas of need.

Sec. 2232. Enhancing the public health workforce. Provides funding to support public health training programs.

Sec. 2233. Public health training centers. Revises the goals for the public health training grant programs to comport with the Secretary's new national prevention and wellness strategy (under Sec. 3121).

Sec. 2234. Preventive medicine and public health training grant program. Provides funding to support training grant programs for preventive medicine physicians.

Sec. 2235. Authorization of appropriations. Authorizes an additional $283 million over the next five years (FY 2011 – FY 2015) for various public health workforce programs to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

SUBTITLE D – ADAPTING WORKFORCE TO EVOLVING HEALTH SYSTEM NEEDS

PART 1 – Health Professions Training for Diversity

Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds. Provides scholarship and loan repayment support for individuals from disadvantaged backgrounds serving in the health professions. Provides funding for the Health Careers Opportunities Program that supports health professions schools that recruit and train individuals from disadvantaged backgrounds.

Sec. 2242. Nursing workforce diversity grants. Clarifies requirements for the Secretary to consult with various nursing associations.

Sec. 2243. Coordination of diversity and cultural competency programs. Requires the Secretary to coordinate workforce diversity and cultural and linguistic competency activities to enhance effectiveness and avoid duplication of effort.

PART 2 – Interdisciplinary Training Programs

Sec. 2251. Cultural and linguistic competence training for health professionals. Establishes a new program to promote cultural and linguistic competence among health care professionals.

Sec. 2252. Innovations in interdisciplinary care training. Establishes a new program to support the development and operation of interdisciplinary training programs for health professionals to improve coordination within and across health care settings, including training in medical home models and models that integrate physical, mental, or oral health services.

PART 3 – Advisory Committee on Health Workforce Evaluation and Assessment

Sec. 2261. Health workforce evaluation and assessment. Creates an Advisory Committee on Health Workforce Evaluation and Assessment to assess the adequacy and appropriateness of the nation's health workforce, and to make recommendations to the Secretary on federal workforce policies to ensure that such workforce is meeting the nation's needs.

PART 4 – Health Workforce Assessment

Sec. 2271. Health workforce assessment. Requires the Secretary to collect data on the supply, diversity, and geographic distribution of the Nation's health workforce, including individuals participating in various federal workforce programs.

PART 5 – Authorization of Appropriations

Sec. 2281. Authorization of appropriations. Authorizes an additional $1.0 billion over the next five years (FY 2011 – FY 2015) for various workforce programs (including Centers of Excellence) to be appropriated from the

Public Health Investment Fund (under section 2002). (Such funds are over and above the level of appropriations provided in FY 2008.)

TITLE III – PREVENTION AND WELLNESS

Sec. 2301. Prevention and wellness. Amends the Public Health Service Act (PHSA) to establish a new Title XXXI that includes 11 new PHSA sections – Sec. 3111, 3121, 3131, 3132, 3141, 3142, 3143, 3151, 3161, 3162, and 3171 (described below).

SUBTITLE A – PREVENTION AND WELLNESS TRUST

Sec. 3111. Prevention and wellness trust. Establishes a Prevention and Wellness Trust that authorizes appropriations from the Public Health Investment Fund (under Sec. 2002) of $15.4 billion over the next five years (FY 2011 – FY 2015) to fund activities under Subtitle C (Prevention Task Forces), Subtitle D (Prevention and Wellness Research), Subtitle E (Delivery of Community-Based Prevention and Wellness Services) and Subtitle F (Core Public Health Infrastructure and Activities) of new PHSA Title XXXI.

SUBTITLE B – NATIONAL PREVENTION AND WELLNESS STRATEGY

Sec. 3121. National prevention and wellness strategy. Requires the Secretary to develop and periodically update a national strategy designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities.

SUBTITLE C – PREVENTION TASK FORCES

Sec. 3131. Task Force on Clinical Preventive Services. Converts the existing U.S. Preventive Services Task Force into the Task Force on Clinical Preventive Services. The charge to the Task Force is to conduct evidence-based systemic reviews of data and literature to determine which clinical preventive services (*i.e.*, preventive services delivered by traditional health care providers in clinical settings) are scientifically proven to be effective.

Sec. 3132. Task Force on Community Preventive Services. Codifies the existing Task Force on Community Preventive Services. The charge to the Task Force is to conduct evidence-based systematic reviews of data and literature to determine which community preventive services (*i.e.*, preventive services that are delivered outside traditional clinical settings and frequently implemented across targeted groups) are scientifically proven to be effective.

SUBTITLE D—PREVENTION AND WELLNESS RESEARCH

Sec. 3141. Prevention and wellness research activity coordination. Directs the CDC and NIH directors to take into consideration the national strategy on prevention (under Sec. 3121), recommendations from the Task Force on Clinical Preventive Services (under Sec. 3131), and recommendations from the Task Force on Community Preventive Services (under Sec. 3132) in conducting or supporting research on prevention and wellness.

Sec. 3142. Community prevention and wellness research grants. Provides support for CDC research on community preventive services.

Sec. 3143. Research on subsidies and rewards to encourage wellness and healthy behaviors. Provides support for research on incentivizing proven healthy behaviors and for the inclusion of effective incentive programs in the essential benefits package or in community prevention and wellness programs.

SUBTITLE E – DELIVERY OF COMMUNITY PREVENTION AND WELLNESS SERVICES

Sec. 3151. Community prevention and wellness services grants. Establishes a grant program to support the delivery of evidence-based, community-based prevention and wellness services across the country. Eligible entities include state and local governments, nonprofits, and consortia such as community partnerships representing Health Empowerment Zones. At least 50% of grant funds must be spent on implementing services whose primary purpose is to reduce health disparities.

SUBTITLE F – CORE PUBLIC HEALTH INFRASTRUCTURE

Sec. 3161. Core public health infrastructure for State, local, and tribal health departments. Establishes a grant program at CDC to improve core public health infrastructure at the state, local, and tribal level. Includes formula grants to state health departments and competitive grants for state, local or tribal health departments. Establishes a public health accreditation program for public health departments and laboratories.

Sec. 3162. Core public health infrastructure and activities for CDC. Provides support for CDC to address unmet and emerging public health needs.

SUBTITLE G—GENERAL PROVISIONS

Sec. 3171. Definitions. Defines various terms for the purposes of PHSA Title XXXI. Provides for transitioning the existing U.S. Preventive Services Task Force into the new Task Force on Clinical Preventive Services and for transitioning the existing Task Force on Community Preventive Services into the new Task Force on Community Preventive Services.

TITLE IV—QUALITY AND SURVEILLANCE

Sec. 2401. Implementation of best practices in the delivery of health care. Creates a Center for Quality Improvement to identify, develop, evaluate and help implement best practices.

Sec. 2402. Assistant Secretary for health information. Establishes the position of Assistant Secretary for Health Information to provide health information on key health indicators; to facilitate better data sharing; and to develop standards for the collection of data to study and address health disparities.

Sec. 2403. Authorization of appropriations. Authorizes an additional $1.5 billion over the next five years (FY 2011 – FY 2015) for quality improvement and data-related activities to be appropriated from the Public Health Investment Fund (under Sec. 2002). (Such funds are over and above the level of appropriations provided for FY 2008.)

TITLE V – OTHER PROVISIONS

SUBTITLE A – DRUG DISCOUNT FOR RURAL AND OTHER HOSPITALS; 340B PROGRAM INTEGRITY

Sec. 2501. Expanded participation in 340B program. Extends the section 340B discounts to certain critical access hospitals, children's hospitals, cancer hospitals, and other entities.

Sec. 2502. Improvements to 340B program integrity. Establishes new auditing, reporting, and other compliance requirements for the Secretary, and for pharmaceutical manufacturers and 340B covered entities.

Sec. 2503. Effective date. Establishes the effective date of sections 2501, 2502(a)(3), and 2502(b)(1) as the date of enactment of this Act, and specifies that the amendments made by Section 2502 take effect on October 1, 2010.

SUBTITLE B – PROGRAMS

PART 1 – Grants for Clinics and Centers

Sec. 2511. School-based health clinics. Establishes a new program to support school-based health clinics that provide health services to children and adolescents. Authorizes $50 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2512. Nurse-managed health centers. Establishes a new program to support nurse-managed health centers (centers operated by advanced practice nurses that provide comprehensive primary care and wellness services to underserved or vulnerable populations). Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2513. Federally qualified behavioral health centers. Sets forth criteria for the certification of federally qualified behavioral health centers and recognizes the role of such centers as safety net providers for individuals with behavioral, mental health, and substance abuse disorders.

PART 2 – Other Grant Programs

Sec. 2521. Comprehensive programs to provide education to nurses and create a pipeline to nursing. Establishes a new program at the Department of Labor to address projected nurse shortages; to increase the capacity for educating nurses; and to support training programs. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2522. Mental and behavioral health training. Establishes a new training program for mental and behavioral health professionals (including those specializing in substance abuse counseling and addiction medicine) to promote interdisciplinary training and coordination of the delivery of health care. Authorizes $60 million for each of FY 2011 through FY 2015 to carry out this program. Requires that no less than 15% of funds be used for training programs in psychology.

Sec. 2523. Reauthorization of telehealth and telemedicine grant programs. Reauthorizes programs to support telehealth networks and telehealth resource centers and to provide incentives to coordinate telemedicine licensure activities among states. Authorizes $10 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out each of the three programs.

Sec. 2524. No child left unimmunized against influenza: demonstration program using elementary and secondary schools as influenza vaccination centers. Establishes new program of demonstration projects to study the feasibility of using elementary and secondary schools as influenza vaccination centers. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2525. Extension of Wisewoman Program. Reauthorizes the NIH Wisewoman ("Well-Integrated Screening and Evaluation for Women Across the Nation") Program and removes the three-state limitation on state participation in the program. Wisewoman consists of demonstration projects to provide preventive health (and appropriate follow-up) services to women. Authorizes $70 million for FY 2011; $73 million for FY 2012; $77 million for FY 2013; $81 million for FY 2014; and $85 million for FY 2015 to carry out this program.

Sec. 2526. Healthy teen initiative to prevent teen pregnancy. Establishes a new program for states to provide evidence-based education to reduce teen pregnancy or sexually transmitted infections. Permits states to work with public or private nonprofit organizations, including schools and community-based and faith-based organizations. Authorizes $50 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2527. National training initiatives on autism spectrum disorders. Establishes a new program to support training activities to address the unmet needs of children and adults with autism and related developmental

disabilities. Authorizes $17 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2528. Implementation of medication management services in treatment of chronic diseases. Establishes a new program to implement medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases.

Sec. 2529. Postpartum depression. Encourages the Secretary to expand and intensify activities on postpartum conditions, including research, epidemiological studies, the development of improved screening and diagnostic techniques, and information and education programs. Requires the Secretary to conduct a study on the benefits of screening for postpartum conditions. Expresses the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study on the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways. Authorizes such sums as may be necessary for each of FY 2011 through FY 2013 to carry out these activities.

Sec. 2530. Grants to promote positive health behaviors and outcomes. Establishes a new training program for community heath workers to promote positive health behaviors (e.g., improved nutrition, decreased tobacco use) among populations in medically underserved areas. Authorizes $30 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2531. Medical liability alternatives. Establishes an incentive program for States to adopt and implement alternatives (certificate of merit or "early offer") as alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorneys' fees or impose caps on damages. Authorizes such sums as may be necessary to carry out this program.

Sec. 2532. Infant mortality pilot programs. Establishes a new program to support pilot projects designed to reduce infant mortality. Authorizes $10 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2533. Secondary school health sciences training program. Establishes a new program to support health sciences curricula in public secondary schools, including middle schools, to prepare students for careers in health professions. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2534. Community-based collaborative care networks. Establishes a new program to support community-based collaborative care networks, a consortium of health care providers offering coordinated and integrated health care services for low-income patient populations or medically-underserved communities. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2535. Community-based overweight and obesity prevention program. Establishes a new program to prevent overweight and obesity among children through improved nutrition and increased physical activity. Authorizes $10 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2536. Reducing student-to-school nurse ratios. Establishes a demonstration program to reduce the student-to-school nurse ratio in public elementary and secondary schools. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2537. Medical-legal partnerships. Establishes a nationwide demonstration program to evaluate the effectiveness of medical-legal partnerships in assisting patients and their families in navigating health-related programs and activities. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program.

PART 3 – Emergency Care-Related Programs

Sec. 2551. Trauma care centers. Establishes a new program to strengthen the nation's emergency room and trauma center capacity. Authorizes $100 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program.

Sec. 2552. Emergency care coordination. Creates an Emergency Care Coordination Center within the HHS Office of the Assistant Secretary for Preparedness and Response. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out the various activities of the Center.

Sec. 2553. Pilot programs to improve emergency medical care. Establishes a pilot program for the design, implementation, and evaluation of innovative models of regionalized, comprehensive, and accountable emergency care systems. Authorizes $12 million for each of FY 2011 through FY 2015 to carry out this program.

Sec. 2554. Assisting veterans with military emergency medical training to become State-licensed or certified emergency medical technicians (EMTs). Establishes a new program for states to assist veterans with military emergency medical training in becoming state-licensed or certified medical technicians. Authorizes sums as may be necessary for each of FY 2011 through FY 2015 to carry out this program. Requires the GAO to conduct a study on the barriers experienced by veterans with military emergency training in becoming licensed or certified civilian health professionals.

Sec. 2555. Dental emergency responders: public health and medical response. Clarifies that dental health facilities are to be included among the medical providers whose preparedness for public health emergencies is to be addressed in the National Health Security Strategy, and that emergency curricula and training programs may be carried out at federal dental health facilities.

Sec. 2556. Dental emergency responders: homeland security. Clarifies that the term ''emergency response provider'' includes emergency dental personnel, agencies, and authorities; that the Department of Homeland Security's Chief Medical Officer serves as the Department's primary point of contact with the dental as well as the medical community; and that the operational plans for a coordinated federal response to natural and man-made disasters and terrorism include the preparedness and deployment of dental as well as public health and medical resources.

PART 4 – Pain Care and Management Programs

Sec. 2561. Institute of Medicine Conference on Pain. Requires the Secretary to seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain. Authorizes $500,000 for each of FY 2011 and FY 2012 to carry out the conference.

Sec. 2562. Pain research at National Institutes of Health. Encourages the NIH Director to continue and expand, through the Pain Consortium, a program of basic and clinical research on pain, including research on the treatment of pain.

Sec. 2563. Public awareness campaign on pain management. Requires the Secretary to establish and implement a national education outreach and awareness campaign on pain management. Authorizes $2 million for FY 2011 and $4 million for each of FY 2012 through FY 2015 to carry out the campaign.

SUBTITLE C – FOOD AND DRUG ADMINISTRATION

PART 1 – In General

Sec. 2571. National medical device registry. Establishes a national directory for class III medical devices and class II devices that are permanently implantable, life-supporting, or life-sustaining. Device information in the registry would be linked with patient safety and outcomes data from various public and private databases to facilitate analyses of post-market device safety and effectiveness.

Sec. 2572. Nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines. Requires chain restaurants to put the calorie content of their menu items directly on the menus and to make other nutritional information available so that consumers can make informed choices about what they eat.

Sec. 2573. Protecting consumer access to generic drugs. Enhances competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs.

PART 2 – Biosimilars

Sec. 2575. Licensure pathway for biosimilar biological products. Establishes a process under which the Secretary is required to approve applications for biological products that have been shown to be biosimilar or interchangeable to an already licensed biological product (the reference product). Requires notification to the Federal Trade Commission and the Assistant Attorney General of certain types of agreements regarding biosimilar or reference products.

Sec. 2576. Fees relating to biosimilar biological products. Allows for the collection of user fees for the approval of biosimilar or interchangeable biological products.

Sec. 2577. Amendments to certain patent provisions. Establishes that a biological product applicant's submission of a statement regarding patents identified by the patent holder constitutes an act of infringement of the patents that claim the biological product.

SUBTITLE D – COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

Sec. 2581. Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program). Establishes a new, voluntary, public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day.

SUBTITLE E – MISCELLANEOUS

Sec. 2585. States failing to adhere to certain employment obligations. Conditions a state's eligibility for funds under the PHSA on a state's agreement to be subject in its capacity as an employer to each employer obligation under Division A of this legislation. Assures that all political subdivisions in the state, and their agencies and instrumentalities, will also be subject to such employer obligations.

Sec. 2586. Health centers under Public Health Service Act; liability protections for volunteer practitioners. Extends medical malpractice liability protection currently available for employees or licensed or certified health professionals under contract with a community health centers to volunteer practitioners providing uncompensated services at such centers.

Sec. 2587. Report to Congress on the current state of parasitic diseases that have been overlooked among the poorest Americans. Requires the Secretary to conduct a study on the epidemiology of, impact of, and appropriate funding required to address neglected diseases of poverty, including Chagas Disease, cysticercosis, toxocariasis, toxoplasmosis, trichomoniasis, soil-transmitted helminthes.

Sec. 2588. Office of Women's Health. Codifies the HHS Office of Women's Health and within the director's office of each of the following HHS agencies: Agency for Health Research and Quality, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration.

Sec. 2589. Long-Term care and family caregiver support. Creates advisory panel and a pilot program focused on improving the working conditions and training for the long-term care workforce. Increases the authorization for the Family Caregiver Support Program to $260 million for each of FY 2011 through FY 2013.

Sec. 2590. Web site on health care labor market and related educational and training opportunities. Requires the Secretary of Labor to establish a web site that would serve as a clearinghouse of information on the health care labor market, including educational and training opportunities and financial aid information.

Sec. 2591. Online health workforce training programs. Establishes a new program for the Secretary of Labor to support online training of health care workers. Authorizes $50 million for each of FY 2011 through FY 2020 to carry out this program.

Sec. 2592. Access for individuals with disabilities. Requires the development of standards for accessible medical equipment, and requires relevant agencies to ensure that all entities covered by this legislation meet the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

DIVISION D— INDIAN HEALTH

TITLE I – AMENDMENTS TO INDIAN LAWS

Sec. 3101. Amendments to the Indian Health Care Improvement Act. Reauthorizes and amends the entire Indian Health Care Improvement Act as laid out below.

Sec. 1. Short Title; Table of Contents. Denotes the Short Title, the "Indian Health Care Improvement Act." and contains the table of contents.

Sec. 2. Findings. Sets out Congressional findings that federal Indian health services are required by the government's historical and legal relationship with Indian people.

Sec. 3. Declaration of National Indian Health Policy. Declares that the National Indian Health Policy is to assure the highest possible health status for Indians and to provide all resources necessary to effectuate the policy.

Sec. 4. Definitions. Defines 28 terms used throughout the Indian Health Care Improvement Act.

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Sec. 101. Purpose. States that the purpose of IHCIA Title I is to increase the number of Indian health professionals, to the maximum extent feasible, and to assure an optimum supply of health professionals for IHS, tribal, and urban Indian health care entities.

Sec. 102. Health Professions Recruitment Program for Indians. Authorizes grants to tribes, tribal organizations, urban Indian organizations, and public and nonprofit entities for recruitment of Indians into health professions.

Sec. 103. Health Professions Preparatory Scholarship Program for Indians. Authorizes scholarships to Indians for compensatory pre-professional education as well as pre-graduate education leading to a baccalaureate degree in a preparatory field for a health profession.

Sec. 104. Indian Health Professions Scholarships. Authorizes scholarships to Indians enrolled full- or part-time in accredited schools pursuing courses of study in the health professions, in accordance with Sec. 338A of the Public Health Service Act (42 U.S.C. 254l).

Sec. 105. American Indians into Psychology Program. Authorizes grants for developing and maintaining Indian psychology career recruitment programs.

Sec. 106. Scholarship Programs for Indian Tribes. Directs the Secretary to make grants to tribes and tribal organizations for scholarships to educate Indians to serve as health professionals in Indian communities.

Sec. 107. Indian Health Service Extern Programs. Authorizes an extern program for enrollees in health professions recruitment programs under Sec. 102(a), including high school programs.

Sec. 108. Continuing Education Allowances. Authorizes the Secretary to provide programs or allowances for individuals to transition into Indian Health Programs. The Sec. also authorizes programs and allowances for IHS and tribal health professionals to take leave of their duty for professional consultation and for refresher training, professional management, and leadership training courses.

Sec. 109. Community Health Representative Program. Directs the Secretary to establish through IHS, tribes, and tribal organizations a program of health paraprofessionals, called Community Health Representatives (CHRs), to provide health care, health promotion, and disease prevention services in Indian communities.

Sec. 110. Indian Health Service Loan Repayment Program. Directs the Secretary to establish a loan repayment program for health professionals who contract to work for a specified time for, or are already employed by, Indian Health Programs or urban Indian health programs.

Sec. 111. Scholarship and Loan Repayment Recovery Fund. Establishes a fund, consisting of such amounts collected from contract breaches under Sections 104, 106, and 110, plus any appropriation to the Fund and interest. The fund will be used to finance scholarships, recruitment efforts and to employ health professionals.

Sec. 112. Recruitment Activities. Authorizes the Secretary to reimburse certain travel expenses to health professionals seeking either employment with Indian Health Programs or urban Indian health programs, or loan repayment contracts under Sec. 110.

Sec. 113. Indian Recruitment and Retention Program. Requires the Secretary to fund, on a competitive basis, demonstration projects to enable Indian Health Programs and urban Indian organizations to recruit, place, and retain health professionals to meet their staffing needs.

Sec. 114. Advanced Training and Research. Directs the Secretary to establish a program to enable health professionals who have worked for an IHS, tribal, or urban Indian health program for a substantial period of time to pursue advanced training or research in areas of study where the Secretary determines a need exists.

Sec. 115. Quentin N. Burdick American Indians Into Nursing Program. Requires the Secretary to make grants to nursing schools, tribally-controlled, community and vocational colleges, and nurse mid-wife and advanced practice nurse programs to increase the number of nurses serving Indians, through scholarships, recruitment, continuing education or other programs encouraging nursing services to American Indians .

Sect.116. Tribal Cultural Orientation. Requires the Secretary to establish a mandatory training program, for appropriate IHS employees serving tribes in each IHS Area, in the history and culture of the tribes they serve and the tribes' relationship to IHS.

Sec. 117. Indians Into Medicine Program. Authorizes the Secretary to provide grants to colleges and universities to maintain and expand the Indians Into Medicine Program (INMED).

Sec. 118. Health Training Programs of Community Colleges. Requires the Secretary to award grants to accredited and accessible community colleges to assist in establishing health profession education programs leading to a degree or diploma for individuals desiring to practice on or near an Indian reservation or in an Indian Health Program.

Sec. 119. Retention Bonus. Authorizes the Secretary to pay retention bonuses to any health professional employed by an IHS or tribal or urban Indian health program who agrees to continue their current employment for not less than one year.

Sec. 120. Nursing Residency Program. Requires the Secretary to establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses working for an Indian Health Program or urban Indian health program for at least 1 year to pursue advanced training in a residency program.

Sec. 121. Community Health Aide Program. Directs the Secretary to develop and operate a Community Health Aide Program (CHAP) in Alaska, under which IHS trains Alaska Natives to provide health care, health promotion, and disease prevention in rural Alaska Native villages.

Sec. 122. Tribal Health Program Administration. Requires the Secretary to provide training to Indians in the administration and planning of Tribal Health Programs.

Sec. 123. Health Professional Chronic Shortage Demonstration Programs. Authorizes the Secretary to fund demonstration programs for Tribal Health Programs to address chronic shortages in health professionals.

Sec.124. National Health Service Corps. Prohibits the Secretary from removing a member of the National Health Service Corps from an IHS or tribal or urban Indian health program, or withdrawing funding to support such member, unless the Secretary ensures that Indians will experience no reduction in services.

Sec. 125. Substance Abuse Counselor Educational Curricula Demonstration Programs. Allows the Secretary to enter into contracts with or make grants to accredited and accessible tribal community colleges, tribal vocational colleges, and eligible community colleges to establish demonstration programs developing educational curricula for substance abuse counseling.

Sec. 126. Behavioral Health Training and Community Education Programs. Improves access to behavioral health services through training and educations programs.

Sec. 127. Exemption from Payment of Certain Fees. Exempts employees of a Tribal Health Program or an urban Indian organization from the payment of licensing, registration, and other fees imposed by a Federal agency, to the same extent that Public Health Service Commissioned Corps officers or other IHS employees are exempt from the fees.

Sec. 128. Authorization of Appropriations. Authorizes appropriations of such sums as are necessary to carry out Title I of this Act.

TITLE II—HEALTH SERVICES

Sec. 201. Indian Health Care Improvement Fund. Authorizes the use of funds, designated the "Indian Health Care Improvement Fund" (IHCIF), to eliminate tribes' health status and resource deficiencies.

Sec. 202. Health Promotion and Disease Prevention Services. Directs the Secretary to provide health promotion and disease prevention services to Indians and to submit to the President an evaluation statement of the resources required to undertake these activities.

Sec. 203. Diabetes Prevention, Treatment, and Control. Provides for the monitoring and treatment of diabetes, as well as data collection and dissemination.

Sec. 204. Shared Services for Long-term Care. Authorizes the Secretary to provide long-term care services at any long-term care or related facility owned or operated by a Tribal Health Program directly or under ISDEAA.

Sec. 205. Health Services Research. Authorizes funding for clinical and nonclinical research to further the performance of Indian Health Programs' responsibilities.

Sec. 206. Mammography and Other Cancer Screening. Requires the Secretary to provide for screening mammography for Indian women, as well as certain other cancer screening that complies with the recommendations of the United States Preventive Services Task Force.

Sec. 207. Patient Travel Costs. Authorizes the Secretary to provide funds for specified patient travel costs associated with receiving IHS-funded health care services.

Sec. 208. Epidemiology Centers. Requires the Secretary to establish an epidemiology center in each IHS Area to carry out specified functions in consultation with tribes and tribal and urban Indian communities.

Sec. 209. Comprehensive School Health Education Programs. Authorizes the Secretary to provide grants to tribes and tribal organizations to develop comprehensive school health education.

Sec. 210. Indian Youth Program. Authorizes the Secretary to make grants to tribes and tribal and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

Sec. 211. Prevention, Control, and Elimination of Communicable and Infectious Diseases. Authorizes the Secretary to make grants to tribes and tribal and urban Indian organizations for projects to prevent, control, and eliminate communicable and infectious diseases.

Sec. 212. Other Authority for Provision of Services. Authorizes the Secretary to provide funding for health-care-related services and programs (not otherwise specified in the Act) for hospice care, assisted living, long-term care, and home- and community-based services.

Sec. 213. Indian Women's Health Care. Requires the Secretary, acting through IHS, to monitor and improve the quality of Indian women's health care delivered through programs administered by IHS.

Sec. 214. Environmental and Nuclear Health Hazards. Requires the Secretary to study and monitor environmental hazards related to mining which may result in chronic or life threatening health problems. Requires the Secretary to develop health care plans to address the health problems studied. Establishes an intergovernmental task force.

Sec. 215. Arizona as a Contract Health Service Delivery Area. Designates Arizona as a contract health service delivery area.

Sec. 216. North Dakota and South Dakota as Contract Health Service Delivery Area. Designates North Dakota and South Dakota as one contract health service delivery area.

Sec. 217. California Contract Health Services Program. Authorizes the Secretary to fund a program using the California Rural Indian Health Board (CRIHB) as a contract care intermediary to improve the accessibility of health services to California Indians.

Sec. 218. California as a Contract Health Service Delivery Area. Designates the State of California, excluding 20 specified counties, as a contract health service delivery.

Sec. 219. Contract Health Services for the Trenton Service Area. Directs the Secretary to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in North Dakota and Richland, Roosevelt, and Sheridan counties in Montana.

Sec. 220. Programs Operated by Indian Tribes and Tribal Organization. Requires that IHS provide funds for health care programs, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same basis as funds are provided to health care programs, functions, services, activities, information technology, and facilities operated directly by IHS.

Sec. 221. Licensing. Requires that licensed health care professionals employed by a Tribal Health Program shall, if licensed in any state, be exempt from the licensing requirements of the state in which the Tribal Health Program provides its services under an ISDEAA contract or compact while performing such services.

Sec. 222. Notification of Provision of Emergency Contract Health Services. Allows 30 days for notification to IHS of any emergency medical care or services received by an elderly or disabled Indian from a non-IHS provider or in a non-IHS facility.

Sec. 223. Prompt Action on Payment of Claims. Requires IHS to respond to notification of a claim by a provider of a contract care service within five working days of receipt of the notification, with either an individual purchase order or a claim denial.

Sec. 224. Liability for Payment. Exempts a patient who receives IHS-authorized contract health care services from being held liable for any charges or costs associated with those authorized services.

Sec. 225. Office of Indian Men's Health. Authorizes the Secretary to establish the Office of Indian Men's Health in IHS.

Sec. 226. Catastrophic Health Emergency Fund (CHEF). Establishes an emergency fund in order to pay for the medical costs associated with the treatment of victims of disasters or catastrophic illnesses.

Sec. 227. Authorization of Appropriations. Authorizes appropriations of such sums as necessary to carry out Title II of this Act.

TITLE III—FACILITIES

Sec. 301. Consultation; Construction and Renovation of Facilities; Reports. Lays out requirements for the Secretary to follow with respect to the construction, renovation and operation of facilities.

Sec. 302. Sanitation Facilities. Lays out responsibilities and requirements pertaining to the construction and maintenance of sanitation facilities.

Sec. 303. Preference to Indians and Indian Firms. Authorizes the Secretary to use the Buy Indian Act (25 U.S.C. 47) to give Indians and Indian firms (as defined in the Sec.) preference in the construction of IHS health care and sanitation facilities pursuant to Sections 301 and 302.

Sec. 304. Expenditure of Non-Service Funds for Renovation. Authorizes the Secretary to accept any major renovation, expansions, or modernization by an Indian tribe or tribal organization of any IHS facility or any health facility operated under ISDEAA and in accordance with criteria established by the Secretary.

Sec. 305. Funding for the Construction, Expansion, and Modernization of Small Ambulatory Care Facilities. Requires the Secretary to make grants to tribes and tribal organizations for Tribal Health Programs to construct, expand, or modernize small ambulatory care facilities.

Sec. 306. Indian Health Care Delivery Demonstration Project. Authorizes the Secretary to make grants to, or construction contracts or agreements with, tribes and tribal organizations under ISDEAA to establish demonstration projects to test alternative health care delivery systems through health facilities to Indians.

Sec. 307. Land Transfer. Authorizes the BIA and all other federal agencies to transfer, at no cost, land and improvements to the IHS for the provision of health care services, and authorizes the Secretary to accept the land.

Sec. 308. Leases, Contracts and Other Agreements. Authorizes the Secretary to enter into leases, contracts, or other agreements with Indian tribes or tribal organizations for the use of facilities owned or leased by the tribes or organizations and used for the delivery of health services by an Indian Health Program.

Sec. 309. Study on Loans, Loan Guarantees, and Loan Repayment. Requires that the Secretary, in consultation with the Secretary of the Treasury and Indian tribes and tribal organizations, carry out a study to determine the feasibility of a loan or loan guarantee fund to provide tribes and tribal organizations either direct loans or loan guarantees for the construction of health care facilities.

Sec. 310. Tribal Leasing. Authorizes Tribal Health Programs to lease permanent structures to provide health care services without prior approval in appropriation Acts.

Sec. 311. Indian Health Service/Tribal Facilities Joint Venture Program. Requires the Secretary to establish joint venture demonstration projects with tribes and tribal organizations under which a tribe or tribal organization shall expend funds, from tribal or non-tribal sources, to acquire or construct a health facility for at least 10 years, under a no-cost lease, in exchange for IHS agreement to provide staffing, equipment, and supplies for the operation and maintenance of the facility.

Sec. 312. Location of Facilities. Identifies conditions when IHS and the BIA are required to give priority to locating facilities and projects on Indian lands, and on any lands in Alaska owned by an Alaska Native village, a village or regional corporation under the Alaska Native Claims Settlement Act, or allotted to an Alaska Native.

Sec. 313. Maintenance and Improvement of Health Care Facilities. Requires the Secretary to submit to the President a report on the backlog of needed maintenance and repairs at IHS and tribal health care facilities, and on the renovation and expansion needs of existing facilities to support the growth of health care programs.

Sec. 314. Tribal Management of Federally Owned Quarters. Authorizes Tribal Health Programs operating a health care facility and the associated federally-owned quarters to establish reasonable rental rates for the federally-owned quarters, by notifying the Secretary, and to collect the rent directly.

Sec. 315. Applicability of Buy American Act Requirement. Requires application of the Buy American Act for all procurements made with funds appropriated under Sec. 317 of the Act (authorization of appropriations for Title III), but exempts Indian tribes and tribal organizations from the requirements of the Buy American Act.

Sec. 316. Other Funding for Facilities. Authorizes the Secretary to accept from any source, including federal and state agencies, funds available for the construction of health care facilities, to use such funds for the planning, design, and construction of Indian health facilities, and to place such funds in ISDEAA contracts and compacts.

Sec. 317. Authorization of Appropriations. Authorizes appropriations of such sums as necessary to carry out Title III of this Act.

TITLE IV—ACCESS TO HEALTH SERVICES

Sec. 401. Treatment of Payments under Social Security Act Health Benefits Programs. Lays out requirements for the treatment of payments received by an Indian Health Program or an urban Indian organization from Medicare, Medicaid, or CHIP.

Sec. 402. Grants to and Contracts with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to Facilitate Outreach, Enrollment, and Coverage of Indians under Social Security Act Health Benefit Programs. Requires the Secretary to make grants or enter into contracts with tribes and tribal organizations to assist individual Indians to enroll in Medicare, Medicaid, and CHIP, and pay premiums and cost sharing required by the programs.

Sec. 403. Reimbursement from Certain Third Parties of Costs of Health Services. Allows the United States, tribes, and tribal organizations the right to recover from third party payors reasonable charges incurred for health services provided to an individual Native Americans.

Sec. 404. Crediting of Reimbursements. Requires that all reimbursements received or recovered for provision of health service by IHS, a tribe, or a tribal or urban Indian organization, shall be credited to the respective entity (including the service unit providing the health service).

Sec. 405. Purchasing Health Care Coverage. Authorizes Indian tribes and tribal and urban Indian organizations to use funds made available for health benefits for IHS beneficiaries to purchase health benefits coverage that meets certain requirements.

Sec. 406. Sharing Arrangements with Federal Agencies. Authorizes the Secretary to enter or expand arrangements for IHS, tribes, and tribal organizations to share medical facilities and services with the Departments of Veterans Affairs (VA) and Defense, but requires consultation with affected tribes prior to finalizing an arrangement.

Sec. 407. Eligible Indian Veteran Services. Requires the Secretary to provide for payment for veteran-related, VA-authorized treatment under a local memorandum of understanding.

Sec. 408. Payor of Last Resort. Specifies that Indian Health Programs and health care programs operated by urban Indian organizations shall be the payor of last resort for services provided to eligible persons.

Sec. 409. Consultation. Cross-references relevant sections of the Social Security Act, regarding consultation with Indian Health Programs and urban Indian organizations with respect to Medicare, Medicaid, and CHIP.

Sec. 410. State Children's Health Insurance Program (SCHIP). Cross-references relevant sections of the Social Security Act regarding outreach to Indian families with children likely to be eligible for CHIP, and ensuring that CHIP assistance is provided to targeted low-income Indian children and that payments are made under CHIP to Indian Health Programs and urban Indian organizations providing such assistance.

Sec. 411. Premium and Cost-Sharing Protections and Eligibility Determinations under Medicaid and SCHIP and Protection of Certain Indian Property from Medicaid Estate Recovery. Cross-references provisions in the Social Security Act relevant to exemption of Indians from Medicaid premiums and cost-sharing, property determinations for Medicaid and CHIP eligibility, and Medicaid estate recovery.

Sec. 412. Treatment under Medicaid and SCHIP Managed Care. Cross-references provisions in the Social Security Act relevant to treatment of Indians enrolled in Medicaid and CHIP managed care entities and treatment of Indian Health Programs and urban Indian organizations that are providers of health care services to Indian enrollees in such entities.

Sec. 413. Navajo Nation Medicaid Agency Feasibility Study. Requires the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries.

Sec. 414. Exception for Excepted Benefits. Directs that the requirements of the previous provisions of Title IV of this Act shall not apply to certain excepted benefits defined in specified sections of the Public Health Service Act.

Sec. 415. Authorization of Appropriations. Authorizes appropriations of such sums as may be necessary to carry out Title IV of this Act.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Sec. 501. Purpose. States that the purpose of Title V is to establish and maintain programs in urban centers to make health services more accessible and available to urban Indians.

Sec. 502. Contracts With, and Grants To, Urban Indian Organizations. Requires the Secretary to enter contracts with or make grants to urban Indian organizations to establish in urban centers programs that meet Title V's requirements.

Sec. 503. Contracts and Grants for the Provision of Health Care and Referral Services. Sets forth the standards, criteria, and uses of funds for contracts and grants for health care services provided to urban Indians.

Sec. 504. Use of Federal Government Facilities and Sources of Supply. Authorizes the Secretary to permit urban Indian organizations carrying out contracts or grants under Title V to use federally owned property, facilities and/or equipment.

Sec. 505. Contracts and Grants for the Determination of Unmet Health Care Needs. Authorizes the Secretary to enter into contracts with or make grants to urban Indian organizations to determine health status and unmet health care needs of the Indians in such urban centers.

Sec. 506. Evaluations; Renewals. Requires the Secretary to develop procedures to evaluate compliance with and performance of contracts and grants, which must include either annual onsite evaluations or evidence of the organization's accreditation by a recognized Medicare review entity.

Sec. 507. Other Contract and Grant Requirements. Requires that contracts with urban Indian organizations be made in accordance with federal contracting laws and regulations relating to procurement.

Sec. 508. Reports and Records. Requires urban Indian contractors and grantees under Title V to submit semi-annual reports to the Secretary containing specified information, including a minimum set of data using uniform elements (specified by the Secretary after consultation with urban Indian organizations).

Sec. 509. Limitation on Contract Authority. Limits the Secretary's authority to enter into contracts or award grants to the amounts appropriated.

Sec. 510. Facilities. Authorizes the Secretary to make funds available to contractors or grantees for leasing, purchasing, renovating, constructing, and expanding facilities, including leased facilities, to comply with applicable licensure or certification requirements.

Sec. 511. Division of Urban Indian Health. Establishes a Division of Urban Health Programs within IHS, responsible for carrying out Title V and overseeing programs and services authorized under the title.

Sec. 512. Grants for Alcohol and Substance Abuse-Related Services. Authorizes the Secretary to make grants to urban Indian contractors and grantees for the provision of alcohol and substance abuse services in urban centers.

Sec. 513. Treatment of Certain Demonstration Projects. Requires that the Oklahoma City and Tulsa demonstration projects in Oklahoma be made permanent programs within IHS's direct care programs.

Sec. 514. Urban NIAAA Transferred Programs. Requires the Secretary to make grants or contracts with urban Indian organizations for the administration of urban Indian alcohol programs.

Sec. 515. Conferring with Urban Indian Organizations. Requires the Secretary to ensure that IHS confers or conferences with urban Indian organizations, to the greatest extent practicable.

Sec. 516. Urban Youth Treatment Center Demonstration. Requires the Secretary to fund construction and operation of at least one residential youth treatment center in each IHS Area meeting certain requirements to demonstrate provision of alcohol and substance abuse treatment services for urban Indian youth in a culturally competent residential setting.

Sec. 517. Grants for Diabetes Prevention, Treatment and Control. Authorizes the Secretary to make grants to urban Indian contractors or grantees for diabetes prevention, treatment, and control.

Sec. 518. Community Health Representatives. Authorizes the Secretary to contract with or make grants to urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under Sec. 109.

Sec. 519. Effective Date. Sets the effective date for the amendments made by this Act as the date of enactment, regardless of whether the Secretary has issued regulations.

Sec. 520. Eligibility for Services. Makes urban Indians eligible for, and the ultimate beneficiaries of, health care and referral services provided under Title V.

Sec. 521. Authorization of Appropriations. Authorizes appropriations of such sums as necessary to carry out Title V of this Act.

Sec. 522. Health Information Technology. Authorizes the Secretary to make grants to urban Indian organizations under Title V for the development, adoption, and implementation of health information technology (as defined in Sec. 3000(5) of the American Recovery and Reinvestment Act), telemedicine services development, and related infrastructure.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Sec. 601. Establishment of the Indian Health Service as an Agency of the Public Health Service. Establishes both the Indian Health Service (IHS) within HHS's Public Health Service and the position of Assistant Secretary for Indian Health.

Sec. 602. Automated Management Information System. Requires the Secretary to establish an automated management information systems for IHS and for each Tribal Health Program, and sets requirements for the systems, including privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Sec. 603. Authorization of Appropriations. Authorizes appropriations of such sums as necessary to carry out Title VI of this Act.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Sec. 701. Behavioral Health Prevention and Treatment Services. Direct the Secretary to develop a comprehensive behavioral health care program that emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

Sec. 702. Memoranda of Agreement with the Department of the Interior. Requires the Secretary and the Secretary of the Interior to develop and enter into memoranda of agreement to assess the mental health care needs and services available or unavailable to Indians and how to ensure and protect Indians' right of access to general mental health services.

Sec. 703. Comprehensive Behavioral Health Prevention and Treatment Program. Requires the Secretary to provide through IHS a program of comprehensive behavioral health, prevention, treatment, and requires that the comprehensive program include prevention, education, specified treatments, rehabilitation, training, and diagnostic services.

Sec. 704. Mental Health Technician Program. Requires the Secretary to establish within IHS a mental health technician training and employment program for Indians.

Sec. 705. Licensing Requirement for Mental Health Care Workers. Requires that, subject to Sec. 221 any person employed as a psychologist, social worker, or marriage and family therapist to provide mental health care services to Indians in a clinic under this Act be licensed to provide the specified service.

Sec. 706. Indian Women Treatment Programs. Authorizes the Secretary to make grants to tribes and tribal and urban Indian organizations to develop and implement a comprehensive behavioral health program for prevention, intervention, treatment, and relapse prevention that specifically addresses the cultural, historical, social, and childcare needs of Indian women.

Sec. 707. Indian Youth Program. Establishes Indian youth behavioral health programs.

Sec. 708. Indian Youth Telemental Health Demonstration Project. Authorizes the Secretary to carry out a demonstration project by making 4-year grants to no more than 5 tribes and tribal organizations with tele-health capabilities to use for telemental health services in youth suicide prevention and treatment.

Sec. 709. Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing. Authorizes the Secretary, through IHS, to provide in each IHS area, not less than one year after enactment of this Act, at least 1 inpatient mental health facility for Indians with behavioral health problems.

Sec. 710. Training and Community Education. Requires that the Secretary to develop and implement in each IHS service unit or tribal program a program of community education in behavioral health issues.

Sec. 711. Behavioral Health Program. Authorizes the Secretary to develop and implement programs to deliver innovative community-based behavioral health services to Indians, and authorizes grants to tribes and tribal organizations for such programs.

Sec. 712. Fetal Alcohol Disorder Programs. Authorizes the Secretary, through IHS, to develop and implement fetal alcohol disorder programs.

Sec. 713. Child Sexual Abuse and Prevention Treatment Programs. Requires the Secretary to establish in every IHS Area treatment programs for child victims of sexual abuse who are Indians or members of Indian households.

Sec. 714. Domestic and Sexual Violence Prevention and Treatment. Authorizes the Secretary to establish programs in each IHS Area to prevent and treat Indian victims of domestic violence or sexual violence, and requires program funds be used for prevention and community education programs, behavioral health services and medical treatment for victims.

Sec. 715. Behavioral Health Research. Requires the Secretary, in consultation with appropriate federal agencies, to make contracts with or grants to tribes, tribal and urban Indian organizations, and appropriate institutions for research on the incidence and prevalence of behavioral health problems among Indians served by IHS, tribes, or tribal organizations and in urban areas.

Sec. 716. Definitions. Defines terms used in Title VII.

Sec. 717. Authorization of Appropriations. Authorizes annual appropriation of such sums as necessary to carry out Title VII of this Act.

TITLE VIII—MISCELLANEOUS

Sec. 801. Reports. Requires the Secretary to submit to Congress reports regarding the various activities authorized under this Act.

Sec. 802. Regulations. Requires the Secretary, within 90 days of enactment of this Act, to initiate negotiated rulemaking for regulations to carry out this Act, except for sections of the Act for which rulemaking under the Administrative Procedures Act is authorized.

Sec. 803. Plan of Implementation. Requires the Secretary, not less than one year after enactment of this Act, and in consultation with tribes and tribal and urban Indian organizations, to submit to Congress a plan detailing by title and section how this Act will be implemented.

Sec. 804. Limitation on Use of Funds Appropriated to Indian Health Service. Provides that any limitation contained in HHS appropriations on the use of federal funds for abortions shall apply for that period with respect to funds appropriated for IHS.

Sec. 805. Eligibility of California Indians. Makes specified California Indians eligible for IHS health services.

Sec. 806. Health Services for Ineligible Persons. Authorizes IHS health services for certain ineligible persons who are children or spouses of eligible Indians.

Sec. 807. Reallocation of Base Services. Prohibits any allocation of IHS funding in a fiscal year that reduces an IHS service unit's recurring programs, projects, or activities by 5% or more from the previous fiscal year unless the Secretary has submitted to Congress a report on the proposed change, the reasons for the change, and the likely effects

Sec. 808. Results of Demonstration Projects. Requires that findings and results of demonstration projects conducted under this Act be disseminated to tribes and tribal and urban Indian organizations.

Sec. 809. Provision of Services in Montana. Requires the Secretary to provide services and benefits for Indians in Montana consistent with the court decision in McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

Sec. 810. Moratorium. Requires IHS to provide services according to eligibility criteria in effect on September 15, 1987, until enactment of specified appropriations to pay for increased costs of eligibility criteria under a final rule published in the Federal Register on September 16, 1987.

Sec. 811. Severability Provisions. Retains remaining provisions of this Act if others are held invalid.

Sec. 812. Use of Patient Safety Organizations. Authorizes IHS, a tribe, or a tribal or urban Indian organization to use a patient safety organization to provide for quality assurance activities, in accordance with Title IX of the Public Health Service Act.

Sec. 813. Confidentiality of Medical Quality Assurance Records; Qualified Immunity for Participants. Makes medical quality assurance records created by an Indian Health Program or an urban Indian health program confidential and privileged, and prohibits their disclosure except to specified entities for specified purposes.

Sec. 814. Claremore Indian Hospital. Provides that Claremore Indian Hospital (in Oklahoma) be deemed a "dependent Indian community" for the purposes of 18 U.S.C. 1151 (which defines "Indian Country" for purposes of certain federal criminal laws).

Sec. 815. Sense of Congress Regarding Law Enforcement and Methamphetamine Issues in Indian Country. Declares that Congress encourages memoranda of agreement among state, local, and tribal law enforcement agencies to streamline law enforcement and maximize limited resources in order to improve law enforcement services in Indian tribal communities and address problems related to methamphetamine use in Indian Country.

Sec. 816. Permitting Implementation through Contracts with Tribal Health Programs. Prohibits construing any provision of this Act as preventing the Secretary from carrying out the Act through contracts with Tribal Health Programs, or from carrying out specified sections in Titles II and VII of this Act through contracts with urban Indian organizations.

Sec. 817. Authorization of Appropriations; Availability. Authorizes annual appropriations of such sums as necessary to carry out Title VIII.

TITLE I CONTINUED – AMENDMENTS TO INDIAN LAWS

Sec. 3102. Soboba Sanitation Facilities. Authorizes sanitation facilities for the Soboba Band of Mission Indians.

Sec. 3103. Native American Health and Wellness Foundation. Directs the Secretary to establish the Foundation and specifies that the Foundation's duties are to encourage, accept, and administer private gifts of property and income for the benefit of, or in support of, the mission of IHS; to undertake activities that will further the health and wellness activities and opportunities of Native Americans; and to participate with and assist federal, state, and tribal governments, agencies, entities, and individuals in such undertaking.

Sec. 3104. GAO Study and Report on Payments for Contract Health Services. Requires the GAO, in consultation with IHS, tribes, and tribal organizations, to study use of health care services provided under the contract health services (CHS) program.

TITLE II. IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

Sec. 3201. Expansion of Payments under Medicare, Medicaid and SCHIP for All Covered Services Furnished by Indian Health Programs. Amends the Social Security Act to provide that Indian Health Programs are eligible for Medicare and Medicaid payments for all items and services if the provision of those services meets all the conditions and requirements generally applicable to the delivery of such care under each respective program.

Sec. 3202. Additional Provisions to Increase Outreach to, and Enrollment of, Indians in SCHIP and Medicaid. Amends the Social Security Act to ensure payment for child health services provided to Indian children who are CHIP eligible.

Sec. 3203. Solicitation of Proposals for Safe Harbors under the Social Security Act for Facilities of Indian Health Programs and Urban Indian Organizations. Directs the Secretary, through the HHS Inspector General, to publish a notice soliciting a proposal, not later than July 1, 2010, on the development of safe harbors for health care items and services provided by Indian Health Programs or urban Indian organizations.

Sec. 3204. Annual Report on Indians Served by Social Security Act Health Benefit Programs. Requires the Secretary, beginning January 1, 2011, and acting through CMS and IHS, to submit an annual report to Congress covering the enrollment and health status of Indians receiving items or services under the health benefit programs funded under the SSA during the preceding year.

Sec. 3205. Recommendations to Improve Interstate Coordination of Medicaid and SCHIP Coverage of Indian Children. Requires the Secretary to conduct a study to identify barriers to interstate coordination of enrollment and coverage of Medicaid- and SCHIP-enrolled children who frequently change their state of residence or may be temporarily outside their state of residence for a variety of reasons (e.g., educational needs, family migration, and emergency evacuations).