America's Affordable Health Choices Act Section-by-Section Analysis
July 14, 2009

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 – PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

SUBTITLE A – GENERAL STANDARDS

Sec. 101. Requirements reforming health insurance marketplace. Broadly outlines the standards for reforming the health insurance marketplace.

Sec. 102. 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. 111. Prohibiting pre-existing condition exclusions. Prohibits the application of pre-existing condition exclusions.

Sec. 112. Guaranteed issue and renewal for insured plans. 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. 113. 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. 114. 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. 115. Ensuring adequacy of provider networks. Provides authority to the Health Choices Commissioner to set network adequacy standards that qualified plans must meet.

Sec. 116. Ensuring value and lower premiums. Requires qualified plans to meet a specified medical loss ratio as defined by the Health Choices Commissioner. If plans exceed that limit, rebates to enrollees are required.

SUBTITLE C – STANDARDS GUARANTEEING ACCESS TO ESSENTIAL BENEFITS

Sec. 121. 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, which includes a tier with offerings of additional benefits. Allows for the continued offering of separate excepted benefits packages as in current law outside of the Exchange.

Sec. 122. 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.

Sec. 123. 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. 122, including the establishment of the three tiers of coverage: basic, enhanced and premium.

Sec. 124. 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 period updating of standards in the future.

SUBTITLE D – ADDITIONAL CONSUMER PROTECTIONS

Sec. 131. 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. 132. 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. 133. 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. 134. 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 131-133 should apply to qualified plans outside of the Health Insurance Exchange.

Sec. 135. Timely payment of claims. Applies Medicare's timely payment of claims standards to the plans offering coverage through the Exchange.

Sec. 136. Standardized rules for coordination and subrogation of benefits. Requires the Health Choices Commissioner to establish standards for the coordination of benefits and reimbursement of payments in cases involving individuals and multiple sources of coverage (like workers' compensation coordination).

Sec. 137. 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.

SUBTITLE E – GOVERNANCE

Sec. 141. 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. 142. 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. 143. Consultation and coordination. Requires the Health Choices Commissioner to consult with other regulatory bodies and state and federal agencies in carrying out his duties and to ensure appropriate oversight and enforcement.

Sec. 144. 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. 151. Relation to other requirements. Makes clear that this act does not supersede COBRA or HIPAA, including mental health parity and the genetic nondiscrimination act, unless their requirements prevent the application of a requirement of this title.

Sec. 152. Prohibiting discrimination in health care. Prohibits discrimination by health insurers with regard to the provision of high quality care or services.

Sec. 153. 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. 154. Construction regarding collective bargaining. Preserves statutory obligations of employers to collectively bargain with employee representatives over health care.

Sec.155. Severability. Provides that if any part of this act is found unconstitutional, that other parts of the act shall not be affected.

SUBTITLE G – EARLY INVESTMENTS

Sec. 161. Ensuring value and lower premiums. Amends the Public Health Service Act to require health insurance issuers to meet a specified medical loss ratio as defined by the Secretary effective for plan years on or after January 1, 2011. If plans exceed that limit, rebates to enrollees are required. In setting the medical loss ratio, the Secretary is to set this highest level possible that is designed to ensure adequate participation by issuers, competition in the market, and value for consumers.

Sec. 162. Ending health insurance rescission abuse. Prohibits health insurance companies from rescinding coverage except in instances of clear fraud and requires independent review of any rescission determination, effective October 1, 2010.

Sec. 163. 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.

Sec. 164. 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. Employment-based plans must apply to participate and be approved by the Secretary. 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.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

SUBTITLE A – HEALTH INSURANCE EXCHANGE

Sec. 201. 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. 202. 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 10 or fewer employees. In year two, employers with 20 and fewer employees are allowed into the Exchange. In subsequent years, the Health Choices Commissioner is granted authority 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 generally be enrolled in Medicaid, not the Exchange. An exception is made for childless adults with incomes under 133% of poverty ($14,400 per year for an individual) who had other

qualifying coverage within the previous six months. They have the choice to obtain coverage through Medicaid or the Exchange.

Once an individual or an employer enrolls in coverage through the Exchange, they remain eligible for Exchange coverage even if their circumstance changes and 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. 203. 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. 204. 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 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.

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. 205. 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.

Sec. 206. 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. 207. Health Insurance Exchange Trust Fund. Creates a Health Insurance Trust Fund to provide necessary funding for the Health Choices Administration.

Sec. 208. 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.

SUBTITLE B – PUBLIC HEALTH INSURANCE OPTION

Sec. 221. 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. 222. 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. 223. Payment rates for items and services. The Secretary of HHS establishes geographically-adjusted provider payment rates for the public option. For the first three years, those rates are based on Medicare rates with a 5% add-on for practitioners who also participate in the Medicare program. This increase also applies to

practitioners, like pediatricians, who do not typically participate in Medicare. After the first three years, the Secretary is granted greater flexibility in setting rates, but the general rule is that overall spending should remain consistent with the initial levels. Flexibility is provided to the Secretary to create payment rates for services not covered by Medicare, pursue delivery system reforms, make adjustments to offset geographic variations and adjust rates as necessary to assure competitiveness with Exchange-participating plans or for excessive or deficient payments. Medicare providers are presumed to also be participating in the public option unless they opt out. There are no penalties for opting out. The Secretary also has authority to negotiate prescription drug prices for the public option.

Sec. 224. Modernized payment initiatives and delivery system reform. The Secretary is empowered to move forward with delivery system reforms to change the way the public option 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. 225. 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 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 in Medicare. Providers must be excluded from participating in the public option if they are excluded from other federal health programs.

Sec. 226. Application of fraud and abuse provisions. Applies Medicare's anti-fraud and abuse protections to the public health insurance option.

SUBTITLE C – INDIVIDUAL AFFORDABILITY CREDITS

Sec. 241. 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 can enter into Memorandums of Understanding with State Medicaid agencies for such determinations as well and will reimburse such agency for the costs of conducting such determinations. 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. 242. Affordable 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 generally must not be eligible for Medicaid. 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 11% of income, are eligible to obtain income-based affordability credits in the Exchange.

Sec. 243. Affordable premium credit. The affordable 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 11% of income for those at 400% of poverty. The way this phaseout 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.

Sec. 244. 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. 245. 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 Commissioner 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. 246. No Federal payment for undocumented aliens. Prohibits anyone not lawfully present in the United States from obtaining affordability credits.

TITLE III—SHARED RESPONSIBILITY

SUBTITLE A – INDIVIDUAL RESPONSIBILITY

Sec. 301. 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. 311. 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 tax 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. 312. Employer responsibility to contribute towards 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.

Sec. 313. 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.

Sec. 314. 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.

PART 2—Satisfaction of Health Coverage Participation Requirements

Sec. 321. Satisfaction of health coverage participation requirements under the Employee Retirement Income Security Act of 1974. 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 remedies 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. 322. 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. 323. 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. 324. 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 IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

SUBTITLE A – SHARED RESPONSIBILITY

PART 1—Individual Responsibility

Sec. 401. Tax on individuals without acceptable health care coverage. 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 coverage obtained pursuant to the Exchange or an employer offer of coverage.

PART 2—Employer Responsibility

Sec. 411. 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. 412. Responsibilities 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 $250,000. The 8% payroll tax phases in for employers with annual payroll from $250,000 through $400,000.

SUBTITLE B – CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES

Sec. 421. 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.

SUBTITLE C – DISCLOSURES TO CARRYOUT HEALTH INSURANCE EXCHANGE SUBSIDIES

Sec. 431. 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.

SUBTITLE D – OTHER REVENUE PROVISIONS

Sec. 441. Health care surcharge on the top 1.2% of earners. The bill would require the top 1.2% of earners – households with adjusted gross income in excess of $350,000 (married filing a joint return) and $280,000 (single) – to contribute towards the cost of providing access to affordable health care for all Americans through a new health care surcharge. According to the nonpartisan Joint Committee on Taxation, this surcharge would have no impact on 98.8% of households in the United States and would only affect, at most, 4.1% of all small business owners in the United States. The health care surcharge would be imposed at progressive rates so that for married households income in excess of $350,000 and below $500,000 would be subject to a surcharge of 1%, income in excess of $500,000 and below $1 million would be subject to a surcharge of 1.5% and income in excess of $1 million would be subject to a surcharge of 5.4%. The first two rates would be increased to 2% and 3%, respectively, in the event that certain health cost savings are not achieved.

Sec. 442. Delay implementation of worldwide allocation of interest. In 2004, Congress provided taxpayers with an election to take advantage of a liberalized rule for allocating interest expense between United States sources and foreign sources for purposes of determining a taxpayer's foreign tax credit limitation. Although enacted in 2004, this election was not available to taxpayers until taxable years beginning after 2008. Last year, the House of Representatives delayed the phase-in of this new liberalized rule for two years (for taxable years beginning after 2010) as part of the *Housing and Economic Recovery Act of 2008* (P.L. 108-289). The bill would further delay the phase-in of this new rule for an additional nine years (for taxable years beginning after 2019). During the 110th Congress, the House of Representatives voted numerous times on a bipartisan basis to delay the implementation of this future tax benefit as part of: H.R. 3920 by a vote of 264 to 157 (with 38 House Republicans joining 226 House Democrats in support); H.R. 3221 (May vote) by a vote of 322 to 94 (with 95 House Republicans joining 227 House Democrats in support); H.R. 3221 (August vote) by a vote 241 to 172 (with 26 Republicans joining 215 Democrats in support); and H.R. 6049 by a vote of 272-152 (with 45 House Republicans joining 227 House Democrats in support).

Sec. 451. Limitation on treaty benefits for certain deductible payments. The bill would prevent foreign multinational corporations incorporated in tax haven countries from avoiding tax on income earned in the United States by routing their income through structures in which a United States subsidiary of the foreign

multinational corporation makes a deductible payment to a country with which the United States has a tax treaty before ultimately repatriating these earning in the tax haven country. This provision has been modified from a previous version approved by the House of Representatives as part of H.R. 2419 (110th Congress) by a vote of 231 to 191 (with 19 House Republicans joining 212 House Democrats in support) to ensure that foreign multinational corporations incorporated in treaty partner countries will not be affected by this provision.

Sec. 452 and 453. Clarification of the economic substance doctrine. The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance. The courts have not applied the economic substance doctrine uniformly. The bill would clarify the manner in which the economic substance doctrine should be applied by the courts. However, the bill does not change current-law standards used by courts in determining when to utilize an economic substance analysis. Under the provision, in any case in which the economic substance doctrine is relevant to a transaction, the economic substance doctrine would be satisfied only if (1) the transaction changes in a meaningful way (apart from federal income tax consequences) the taxpayer's economic position, and (2) the taxpayer has a substantial non-federal tax purpose for entering into such transaction. The provision also imposes a 20% penalty on understatements attributable to a transaction lacking economic substance (penalty increased to 40% in the case of transactions in which the relevant facts affecting the tax treatment of the transaction are not adequately disclosed). This provision was previously approved by the House of Representatives as part of H.R. 4351 (110th Congress) by a vote of 226 to 193.

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, skilled nursing facilities, inpatient rehabilitation hospitals, psychiatric hospitals and hospice care beginning in 2010. 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.

SUBTITLE B—PROVISIONS RELATED TO PART B

PART 1—Physicians' Services

Sec. 1121. Sustainable growth rate reform. Permanently reforms the formula that annually updates reimbursement rates for physician services in Medicare. The revised formula recognizes the importance of primary care by allowing these services to grow at a higher rate than other services, and does not reduce physician pay rates for increases in spending on drugs or lab services. The policy also encourages physicians to form Accountable Care Organizations by providing these organizations with their own targets and update factors. Updates payment rates by the Medicare Economic Index in 2010 as these reforms are implemented.

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, beginning in 2010.

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. 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. Medicare Improvement Fund. Places $8 billion in the Medicare Improvement Fund.

Sec. 1147. 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. 1148. 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 from the surety bond requirement and the need to be accredited to sell diabetic testing supplies and certain other items.

Sec. 1149. 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.

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. 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 existing 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. Within one year of enactment, the Institute of Medicine will report to CMS on the validity and effects of the geographic adjusters used for Medicare physician and hospital payments, and any recommendations for 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.

SUBTITLE D – MEDICARE ADVANTAGE REFORMS

PART 1—Payment and Administration

Sec. 1161. Phase-in of payment based on fee-for-service costs. Reduces Medicare Advantage benchmarks to fee-for-service levels over three years, reaching equality of payment rates in 2013.

Sec. 1162. Quality bonus payments. Creates an incentive system to increase payments to high quality plans and plans that demonstrate improvement, phased-in over 2011-2013, consistent with the changes in section 1161.

Sec. 1163. 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. 1164. 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. 1165. 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. 1166. 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. 1167. 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. 1168. Elimination of MA Regional Plan Stabilization Fund. Eliminates the Medicare Advantage regional plan stabilization fund.

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%, 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.

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 their eligibility periods.

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.

SUBTITLE E – IMPROVEMENTS TO MEDICARE PART D

Section 1181. Elimination of coverage gap. Eliminates Part D donut hole, beginning with a $500 reduction in 2011, and completing phase-out by 2023. 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.

Section 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 into the bill.

Section 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.

Section 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.

Section 1185. Permitting mid-year changes in enrollment for formulary changes that adversely impact an enrollee. Allows Part D enrollees to change drug plans if the plan makes a change to the formulary that increases cost-sharing or otherwise reduces coverage.

SUBTITLE F—MEDICARE RURAL ACCESS PROTECTIONS

Sec. 1191. Telehealth expansion and enhancements. 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 in a facility for the mentally retarded.

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 HHS 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 HHS 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 in calculation of low income subsidy benchmark. Removes Medicare Advantage rebates 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 End Stage Renal Disease.

Sec. 1233. Advance care planning consultation. Provides coverage for consultation between enrollees and practitioners to discuss orders for life-sustaining treatment. Instructs CMS to modify 'Medicare & You' handbook to incorporate information on end-of-life planning resources and to incorporate measures on advance care planning into the physician's quality reporting initiative.

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/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 program: 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*, is targeted at a broader population of Medicare beneficiaries with chronic diseases and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider. Provides approximately $1.6 billion from the Trust Fund for the 5 year 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 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.

TITLE IV—QUALITY

SUBTITLE A—COMPARATIVE EFFECTIVENESS RESEARCH

Sec. 1401. Comparative effectiveness research. Establishes a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality (AHRQ) to conduct, support and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services, and systems.

Establishes a public/private stakeholder commission known as the "Comparative Effectiveness Research

Commission" to oversee the Center, determine national priorities for research, identify research methods and standards of evidence, support forums to increase stakeholder feedback, appoint advisory panels on specific national priorities to advise the center on research questions and methods, and make recommendations for the dissemination of findings.

The 17-member Commission will be appointed by the Secretary with input from the Comptroller General and the Institute of Medicine and will include the Director of AHRQ, the Chief Medical Officer of CMS and stakeholders including clinicians, patients, researchers, third-party payers and consumers. Clinical perspective advisory panels will provide advice on specific research questions, methods and gaps in evidence in terms of clinical outcomes for priorities identified by the Commission in order to ensure that the research is clinically relevant. The Commission and the advisory panels it appoints will be subject to strict conflict of interest requirements. The Center and the Commission are prohibited from mandating coverage, reimbursement or other policies to any public or private payer. The Center and the research it conducts are funded out of the Comparative Effectiveness Research Trust Fund (CERTF) which will receive contributions from Medicare and private health insurance plans.

SUBTITLE B -- NURSING HOME TRANSPARENCY

PART 1 - Improving Transparency of Information on Skilled Nursing Facilities and Nursing Facilities

Sec. 1411. Required disclosure of ownership and additional disclosable parties information. 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.

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.

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 or entities that bill Medicare 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.

Section 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.

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. Evaluations and reports required 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. Allows the Secretary discretion to expand this requirement to other areas if such an extension would help reduce waste, fraud, and abuse.

Sec. 1638. Requirement for 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. Face to face encounter with patient required 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.

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 133-1/3 percent of the Federal poverty level. (a) Requires State Medicaid programs to cover non-disabled, childless adults under age 65 with income at or below 133% of FPL ($14,400 per year for an individual). The federal government would pay 100% of the costs of Medicaid coverage for this population. Effective in 2013.
(b) Requires State Medicaid programs to cover parents and individuals with disabilities under age 65 with income at or below 133% of FPL ($29,300 per year for a family of 4). The federal government would pay 100% of the costs of Medicaid coverage for individuals in these categories with incomes between the levels in effect in the state as of June 16, 2009 and 133% of FPL. Effective in 2013.
(c) Requires State Medicaid programs to cover newborns up to the first 60 days of life who do not otherwise have acceptable coverage upon birth. The federal government will pay 100% of the costs of Medicaid coverage for these newborns. Effective in 2013.

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 into the Exchange or Medicaid as appropriate.

Sec. 1703. CHIP and Medicaid maintenance of effort. (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 effort ends with the opening of the Health Insurance Exchange in 2013 or, if later, the date on which (1) the Health Choices Commissioner determines that the Exchange has the capacity to support CHIP enrollees and (2) the Secretary of HHS determines that procedures are in effect to ensure timely transition without interruption of coverage.
(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 Medicaid DSH 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 uninsurance rate in each State and the amount of uncompensated care provided by hospitals.

Sec . 1705. Expanded outstationing. Requires State Medicaid programs to allow adults to apply for Medicaid coverage at DSH hospitals, FQHCs, and other locations than welfare offices (requirement already applies to pregnant women and children). Effective July 1, 2010.

SUBTITLE B — PREVENTION

Sec. 1711. Required coverage of preventive services. Requires State Medicaid programs to cover preventive services not otherwise covered that the Secretary determines are recommended by the U.S. Preventive Services Task Force and appropriate for Medicaid beneficiaries. Effective July 1, 2010.

Sec. 1712. Tobacco cessation. Prohibits State Medicaid programs from excluding tobacco cessation products from coverage. Effective July 1, 2010.

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. Effective January 1, 2010.

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. Effective on enactment.

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.

Sec. 1722. Medical home pilot program. Establishes a 5-year pilot program to test the medical home concept with high-need 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. Effective January 1, 2010.

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

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. Effective upon enactment.

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.

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.

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. Effective January 1, 2010.

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. Effective on enactment.

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. Effective on enactment.

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

Sec. 1755. Managed Care Organizations. Limits Medicaid MCO spending on administration, marketing, and distributions to shareholders to no more than 15% of Medicaid premium revenues. Effective July 1, 2010.

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. Effective January 1, 2011.

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. Effective January 1, 2011.

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 Management Information Systems reports to the Secretary data elements necessary for the detection of waste, fraud, and abuse. Effective on enactment.

Sec. 1759. Registration of alternate payees. Requires agents, clearinghouses, or another 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. Effective January 1, 2012.

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. Effective date: January 1, 2010.

SUBTITLE G – PUERTO RICO AND THE TERRITORIES

Sec.1771. Puerto Rico and Territories. Provides additional federal Medicaid matching payments to Puerto Rico and the territories 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, 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.

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; financing for Trust Fund. Establishes the trust fund for the comparative effectiveness research program. Also establishes a fee that is assessed on private insurance on the basis of the number of insured individuals to fund the research program.

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 to improve coordination of benefits and other policies for beneficiaries dually eligible for Medicare and Medicaid.

DIVISION C – PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

Sec. 2001. Table of Contents; References.

Sec. 2002. Public health investment fund. Establishes the Public Health Investment Fund and deposits a total of $89 billion for use over the next ten years (FY 2010 – FY 2019). 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.

TITLE I – COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding. Authorizes an additional $38 billion for use over the next ten years (FY 2010 – FY 2019) 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 $3.9 billion for FY 2010 through FY 2019 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 at HRSA to address health care needs in geographic areas ("health professional needs areas") not currently recognized as health professional

shortage areas. Physicians and other health professionals that do not qualify to participate in the National Health Service Corps are eligible for this program.

Sec. 2212. Primary care student loan funds. Modifies an existing student loan program to make it more attractive for students to pursue careers in primary care by reducing loan interest rate to 2% below otherwise available interest rates and provides for penalties if primary care service requirements are not met.

Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistantship. Provides funding to support primary care training programs and 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 $3 billion for FY 2010 through FY 2019 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.)

SUBTITLE B – NURSING WORKFORCE

Sec. 2221. Amendments to Public Health Service Act. Makes a number of changes 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 $1.45 billion for FY 2010 through FY 2019 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 at HRSA 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 $600 million for FY 2010 through FY 2019 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 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 care professionals. Establishes a grant program at HRSA to promote cultural and linguistic competence of health care professionals.

Sec. 2252. Innovations in interdisciplinary care training. Establishes a grant program at HRSA 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 health workforce, and to make recommendations to the Secretary on federal workforce policies to ensure the health 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 – Authorizing of Appropriations

Sec. 2281. Authorization of appropriations. Authorizes an additional $2.2 billion for FY 2010 through FY 2019 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 by establishing a new Title XXIII and creating 10 new sections – Sec. 3111, 3121, 3131, 3132, 3141, 3142, 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 $35 billion from FY 2010 through FY 2019 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).

SUBTITLE B – NATIONAL PREVENTION AND WELLNESS STRATEGY

Sec. 3121. National prevention and wellness strategy. Requires the Secretary to submit a national strategy designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities within one year of enactment and at least every two years thereafter. The strategy must identify specific national goals and standards and establish national priorities for 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. Staffed by AHRQ, this task force of non-governmental experts conducts evidence-based systemic reviews of data and literature to determine what clinical preventive services (e.g., 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. Staffed by CDC, this task force of non-governmental experts conducts evidence-based systematic reviews of data and literature to determine what community preventive services (e.g., preventive services that are not "clinical preventive services" but are delivered by nontraditional providers in nontraditional settings) 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 funding to CDC to support research on community preventive services.

SUBTITLE E – DELIVERY OF COMMUNITY PREVENTION AND WELLNESS SERVICES

Sec. 3151. Community prevention and wellness services grants. Establishes a grant program at CDC to fund the delivery of evidence-based, community-based prevention and wellness services across the country. Eligible entities include state and local governments, nonprofits, and community partnerships representing Health Empowerment Zones. At least 50% of these 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 health departments and laboratories.

Sec. 3162. Core public health infrastructure and activities for CDC. Authorizes additional funds for CDC to address unmet and emerging public health needs.

SUBTITLE G—GENERAL PROVISIONS

Sec. 3171. Definitions. Defines various terms for the purposes of the new Title XXXI of the Public Health Service Act. 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 at the Agency for Healthcare Research and Quality to focus on quality improvement. The center will prioritize quality improvement activities, identify existing best practices, develop innovative new practices, evaluate these practices and assist entities to implement these 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 on specified populations and subpopulations.

Sec. 2403. Authorization of appropriations. Authorizes an additional $3.1 billion for FY 2010 through FY 2019 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

Sec. 2501. Expanded participation in 340B program. Extends the section 340B discounts for certain rural and other hospitals to inpatient as well as outpatient drugs.

Sec. 2502. Extension of discounts to inpatient drugs. Requires participating hospitals to credit State Medicaid programs with savings resulting from the 340B discounts.

Sec. 2503. Effective date. Establishes the effective date of Subtitle A on July 1, 2010.

SUBTITLE B – SCHOOL-BASED HEALTH CLINICS

Sec. 2511. School-based health clinics. Establishes a program to provide support to school-based health clinics that provide health services to children and adolescents.

SUBTITLE C – NATIONAL MEDICAL DEVICE REGISTRY

Sec. 2521. 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.

SUBTITLE D – GRANTS FOR COMPREHENSIVE PROGRAMS TO PROVIDE EDUCATION TO NURSES AND CREATE A PIPELINE TO NURSING

Sec. 2531. Establishment of grant program. Establishes a grant program at the Department of Labor to address projected nurse shortages, increase the capacity for educating nurses, and provide training programs. Authorizes "such sums as may be necessary" to carry out the program.