period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.

(4) PATTERN OF ABUSE.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) APPLICATION OF THE FALSE CLAIMS ACT.—

(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

[*Section 10104(j)(1), p. 792, provides that subparagraph (B) is deemed "null, void, and of no effect"*]

[(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than

6 times the amount of damages which the Government sustains because of the act of that person.]

[*Section 10104(j)(2),p. 792, replaced paragraph (4) of section 3730(e) of title 31, United States Code*, as follows:]

(2) [*sec. 10104(j)(2) of PPACA:*] Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

"(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

"(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

"(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

"(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

"(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.".

(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges;

(4) [*As added by section 10104(k)(3)*] a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

(5) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

be entitled to payment from the amount allocated to the territory under subsection (c); or

(2) does not make such election shall be entitled to an increase in the dollar limitation applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for such period in such amount for such territory and such increase shall not be taken into account in computing any other amount under such subsections.

(b) TERMS AND CONDITIONS.—An election under subsection (a)(1) shall—

(1) not be effective unless the election is consistent with section 1321 and is received not later than October 1, 2013; and

(2) be contingent upon entering into an agreement between the territory and the Secretary that requires that—

(A) funds provided under the agreement shall be used only to provide premium and cost-sharing assistance to residents of the territory obtaining health insurance coverage through the Exchange; and

(B) the premium and cost-sharing assistance provided under such agreement shall be structured in such a manner so as to prevent any gap in assistance for individuals between the income level at which medical assistance is available through the territory's Medicaid plan under title XIX of the Social Security Act and the income level at which premium and cost-sharing assistance is available under the agreement.

(c) APPROPRIATION AND ALLOCATION.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for purposes of payment pursuant to subsection (a) $1,000,000,000, to be available during the period beginning with 2014 and ending with 2019.

(2) ALLOCATION.—The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, $925,000,000.

(B) For another territory, the portion of $75,000,000 specified by the Secretary.

SEC. 1324. LEVEL PLAYING FIELD.

(a) IN GENERAL.—**[***As revised by section 10104(n)***]** Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law.

(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;

(2) rating;

(3) preexisting conditions;

(4) non-discrimination;

(5) quality improvement and reporting;

(6) fraud and abuse;

(7) solvency and financial requirements;

(8) market conduct;
(9) prompt payment;
(10) appeals and grievances;
(11) privacy and confidentiality;
(12) licensure; and
(13) benefit plan material or information.

PART 4—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax

"(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.".

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: "Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).";

(2) by redesignating paragraph (2) as paragraph (8); and **[***Replaced by section 10603(b)***]**

(3) by inserting after paragraph (1) the following:

"(2) PROVIDER SCREENING.—

"(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

"(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

"(i) shall include a licensure check, which may include such checks across States; and

"(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

"(I) a criminal background check;

"(II) fingerprinting;

"(III) unscheduled and unannounced site visits, including preenrollment site visits;

"(IV) database checks (including such checks across States); and

"(V) such other screening as the Secretary determines appropriate.

"(C) APPLICATION FEES.—[*As revised by section 10603(a)*]

"(i) INSTITUTIONAL PROVIDERS.—Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

"(I) for 2010, $500; and

"(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

"(ii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

"(iii) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

"(D) APPLICATION AND ENFORCEMENT.—

"(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX , or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

"(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

"(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

"(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

"(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

"(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

"(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX. and the CHIP program under title XXI.

"(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

"(4) 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS.—**[***As added by section 1304 of HCERA***]** For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under title XVIII identified pursuant to such determination and who is initially enrolling under such title, the Secretary shall, notwithstanding sections 1816(c), 1842(c), and 1869(a)(2), withhold payment under such title with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such title for durable medical equipment furnished by such supplier. **[***Subsequent paragraphs reflect redesignation by section 1304 of HCERA***]**

"(5) INCREASED DISCLOSURE REQUIREMENTS.—

"(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

"(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

"(6) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

"(B) DEFINITIONS.—In this paragraph:

"(i) IN GENERAL.—The term 'applicable provider of services or supplier' means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

"(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term 'obligated provider of services or supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

"(7) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

"(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

"(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

"(8) COMPLIANCE PROGRAMS.—

"(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

"(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.".

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

(A) in subsection (a)—

(i) by striking "and" at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

"(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);"; and

(B) by adding at the end the following:

"(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

"(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

"(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

"(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

"(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

"(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

"(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

"(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition

of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

"(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

"(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

"(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

"(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

"(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

"(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

"(8) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.".

(2) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date).

(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), is amended by inserting

before the semicolon at the end the following: "or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium".

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 2101(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N), respectively; and

(2) by inserting after subparagraph (C), the following:

"(D) Subsections (a)(77) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).".

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002, 6004, and 6102, is amended by inserting after section 1128I the following new section:

"SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

"(a) DATA MATCHING.—

"(1) INTEGRATED DATA REPOSITORY.—

"(A) INCLUSION OF CERTAIN DATA.—

"(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

"(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

"(II) The program under title XXI.

"(III) Health-related programs administered by the Secretary of Veterans Affairs.

"(IV) Health-related programs administered by the Secretary of Defense.

"(V) The program of old-age, survivors, and disability insurance benefits established under title II.

"(VI) The Indian Health Service and the Contract Health Service program.

"(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

"(B) DATA SHARING AND MATCHING.—

"(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

"(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

"(I) The Commissioner of Social Security.

"(II) The Secretary of Veterans Affairs.

"(III) The Secretary of Defense.

"(IV) The Director of the Indian Health Service.

"(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

"(2) ACCESS TO CLAIMS AND PAYMENT DATABASES.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

"(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

"(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

"(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

"(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f)) regardless of how the item or service is paid for, or to whom such payment is made.

"(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under an MA–PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

"(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

"(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

"(2) APPLICABLE INDIVIDUAL.—For purposes of paragraph (1), the term 'applicable individual' means an individual—

"(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

"(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

"(C) eligible for child health assistance under a child health plan under title XXI.

"(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

"(1) IN GENERAL.—If a person has received an overpayment, the person shall—

"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

"(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

"(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

"(A) the date which is 60 days after the date on which the overpayment was identified; or

"(B) the date any corresponding cost report is due, if applicable.

"(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

"(4) DEFINITIONS.—In this subsection:

"(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

"(B) OVERPAYMENT.—The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

"(C) PERSON.—

"(i) IN GENERAL.—The term 'person' means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

"(ii) EXCLUSION.—Such term does not include a beneficiary.

"(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.".

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–116(f)(2)) is amended by striking

"may be used by" and all that follows through the period at the end and inserting "may be used—

"(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

"(i) carrying out this section; and

"(ii) conducting oversight, evaluation, and enforcement under this title; and

"(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.".

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking "or" at the end;

(B) in clause (viii), by inserting "or" after the semicolon; and

(C) by adding at the end the following new clause:

"(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records with non-Federal records;".

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

"(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

"(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and

"(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

"(B) For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.".

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (23), by striking "or" at the end;

(2) in paragraph (24), by striking the period at the end and inserting "; or"; and

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

"(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).".

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.".

(2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) in paragraph (1)(D), by striking "was excluded" and all that follows through the period at the end and inserting "was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.";

(ii) in paragraph (6), by striking "or" at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

"(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

"(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

"(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;";

(iv) in the first sentence—

(I) by striking the "or" after "prohibited relationship occurs;"; and

(II) by striking "act)" and inserting "act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)"; and

(v) in the second sentence, by striking "purpose)" and inserting "purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which

payment was made based upon the application containing the false statement or misrepresentation of a material fact)".

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(i) in subparagraph (C), by striking "or" at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting "; or"; and

(iv) by adding at the end the following new subparagraphs:

"(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

"(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

"(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

"(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

"(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

"(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

"(i) the items or services are not offered as part of any advertisement or solicitation;

"(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

"(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

"(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

"(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–

2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.".

(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a–7(f)) is amended by adding at the end the following new paragraph:

"(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.".

(f) HEALTH CARE FRAUD.—

(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.".

(2) REVISING THE INTENT REQUIREMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

"(h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.".

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting "that the Secretary determines is commensurate with the volume of the billing of the supplier" before the period at the end.

(2) HOME HEALTH AGENCIES.—Section 1861(o)(7)(C) of the Social Security Act (42 U.S.C. 1395x(o)(7)(C)) is amended by inserting "that the Secretary determines is commensurate with the volume of the billing of the home health agency" before the semicolon at the end.

(3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

"(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

"(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph

is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).".

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

"(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

"(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

"(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

"(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1903(i)(2)(C).".

(2) MEDICAID.—Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

(A) in subparagraph (A), by striking "or" at the end; and

(B) by inserting after subparagraph (B), the following:

"(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or".

(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

"(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

[*Additional paragraph (8), providing additional funding, added by section 1303(a)(1)(A) of HCERA; text shown below***]**

["(8) ADDITIONAL FUNDING.—**]**

[“(A) IN GENERAL.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3)(C) and (4)(A) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated to such Account from such Trust Fund the following additional amounts:]

[“(i) For fiscal year 2011, $95,000,000.]

[“(ii) For fiscal year 2012, $55,000,000.]

[“(iii) For each of fiscal years 2013 and 2014, $30,000,000.]

[“(iv) For each of fiscal years 2015 and 2016, $20,000,000.]

[“(B) ALLOCATION.—The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.”; and]

(B) in paragraph (4)(A), by inserting “until expended” after “appropriation”. [*Note: additional amendment made to paragraph (4)(A) by section 1303(a)(1)(B) of HCERA*]

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting “and” at the end;

(ii) in subclause (IV)—

(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking subclause (V).

(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(i) in subclause (VIII), by inserting “and” at the end;

(ii) in subclause (IX)—

(I) by striking “for each of fiscal years 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting “and” at the end;

(ii) in clause (viii)—

(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

"(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.".

(j) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking "and" at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

(iii) by inserting after paragraph (3) the following new paragraph:

"(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and".

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(i) EVALUATIONS AND ANNUAL REPORT.—

"(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

"(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

"(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

"(B) the effectiveness of the use of such funds.".

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting ", or otherwise," after "entities".

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u–6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

(ii) by inserting after subparagraph (C) the following new subparagraph:

"(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics

(including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.".

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u–7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following new paragraph:

"(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.".

[*Additional amendments to section 1936(e)(1) made by section 1303(b) of HCERA, p. 897*]

(k) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking "individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both" and inserting "beneficiaries (as defined in section 1128A(i)(5)) of that program".

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) by striking subsection (a) and inserting the following:

"(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).";

(2) by striking subsection (d) and inserting the following:

"(d) ACCESS TO REPORTED INFORMATION.—

"(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.";

(3) by striking subsection (f) and inserting the following:

"(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921."; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (iii)—

(I) by striking "or State" each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

"(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction"; and

(ii) by striking clause (iv) and inserting the following:

"(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f))."; (B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking "or State".

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r–2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking "SYSTEM.—The State" and all that follows through the semicolon and inserting SYSTEM.—

"(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:";

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking "the license of" and inserting "license or the right to apply for, or renew, a license by"; and

(II) by inserting "nonrenewability," after "voluntary surrender,"; and

(iv) by adding at the end the following new subparagraph:

"(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency."; and

(B) in paragraph (2), by striking "the authority described in paragraph (1)" and inserting "a State licensing or certification agency or State law or fraud enforcement agency";

(2) in subsection (b)—

(A) by striking paragraph (2) and inserting the following:

"(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;";

(B) in each of paragraphs (4) and (6), by inserting ", but only with respect to information provided pursuant to subsection (a)(1)(A)" before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

"(5) to State law or fraud enforcement agencies,";

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

"(7) to health plans (as defined in section 1128C(c));";

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

"(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

"(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

"(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

"(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

"(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

"(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

"(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

"(g) REFERENCES.—For purposes of this section:

"(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term 'State licensing or certification agency' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review

organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

"(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term 'State law or fraud enforcement agency' includes—

"(A) a State law enforcement agency; and

"(B) a State medicaid fraud control unit (as defined in section 1903(q)).

"(3) FINAL ADVERSE ACTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'final adverse action' includes—

"(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

"(ii) State criminal convictions related to the delivery of a health care item or service;

"(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

"(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

"(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

"(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim."; and

(4) in subsection (h), as so redesignated, by striking "The Secretary" and all that follows through the period at the end and inserting "In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.".

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding "and" after the comma at the end;

(2) in subparagraph (D), by striking ", and" and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(3) FUNDING.—

(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term "transition period" means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(2) PART B.—Section 1835(a)(2) of the Social Security Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j)," after "a physician".

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

"(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.".

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

(1) in subparagraph (U), by striking at the end "and";

(2) in subparagraph (V), by striking the period at the end and adding "; and"; and

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

"(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.".

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting ", ordering, referring for furnishing, or certifying the need for" after "furnishing".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking "and such services" and inserting "such services"; and

(B) by inserting after "care of a physician" the following: ", and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary". [*As revised by section 10605(a)*]

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking "and" before "(iii)"; and

(B) by inserting after "care of a physician" the following: ", and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary". [*As revised by section 10605(b)*]

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

(1) by striking "ORDER.—The Secretary" and inserting "ORDER.—

"(i) IN GENERAL.—The Secretary"; and

(2) by adding at the end the following new clause:

"(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has

had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.".

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking "or" at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

"(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

"(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;"; and

(3) in the first sentence—

(A) by striking "or in cases under paragraph (7)" and inserting "in cases under paragraph (7)"; and

(B) by striking "act)" and inserting "act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)".

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting "timely" before "inspect"; and

(B) in subparagraph (B), by inserting "timely" before "audit and inspect".

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(A) in subparagraph (F), by striking "or" at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

"(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

"(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

"(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

"(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;"; and

(C) by adding at the end the following new sentence: "The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.".

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by inserting "except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination,".

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting "OR AUDIT" after "INVESTIGATION"; and

(2) by striking "investigation into" and all that follows through the period and inserting "investigation or audit related to—"

"(i) any offense described in paragraph (1) or in subsection (a); or

"(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services

"(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and".

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii)—

(A) by inserting "(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)" after "may"; and

(B) by striking the period at the end and inserting "; and"; and

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

"(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).".

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking "that the records" and inserting "that—"(A) the records";

(B) by inserting "and" after the semicolon; and

(C) by adding at the end the following:

"(B) not later than December 31, 2010, the State shall—

"(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

"(ii) provide assurances satisfactory to the Secretary that—

"(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

"(II) from such amounts recovered, payment—

"(aa) shall be made on a contingent basis for collecting overpayments; and

"(bb) may be made in such amounts as the State may specify for identifying underpayments;

"(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

"(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

"(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

"(bb) that section 1903(d) shall apply to amounts recovered under the program; and

"(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and".

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "part A or B" and inserting "this title";

(2) in paragraph (2), by striking "parts A and B" and inserting "this title";

(3) in paragraph (3), by inserting "(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)" after "2010";

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking "part A or B" and inserting "this title"; and

(5) by adding at the end the following:

"(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

"(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

"(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

"(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

"(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.".

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after "1128A," the following: "terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title,".

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6401(b), is amended by inserting after paragraph (77) the following:

"(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

"(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

"(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

"(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period;".

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 6502(a), is amended by inserting after paragraph (78), the following:

"(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;".

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after "necessary" the following: "and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine".

(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting "and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary" after "patients".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

"(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;".

SEC. 6506. OVERPAYMENTS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking "60 days" and inserting "1 year"; and

(ii) in the second sentence, by striking "60 days" and inserting "1-year period"; and

(B) in subparagraph (D)—

(i) in inserting "(i)" after "(D)"; and

(ii) by adding at the end the following:

"(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.".

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking "and" at the end;

(B) in clause (iii), by adding "and" after the semicolon; and

(C) by adding at the end the following new clause:

"(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);"; and

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

"(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

"(A) Not later than September 1, 2010:

"(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

"(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

"(iii) Notify States of—

"(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

"(II) how States are to incorporate such methodologies into claims filed under this title.

"(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).".

SEC. 6508. GENERAL EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle G—Additional Program Integrity Provisions

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

"SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

"No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, or the representative or agent of any such person, State, or the Secretary, concerning—

"(1) the financial condition or solvency of such plan or arrangement;

"(2) the benefits provided by such plan or arrangement;

"(3) the regulatory status of such plan or other arrangement under any Federal or State law governing collective bargaining, labor management relations, or intern union affairs; or

"(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).".

(b) CRIMINAL PENALTIES.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" before "Any person"; and

(2) by adding at the end the following:

"(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.".

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

"Sec. 519. Prohibition on false statement and representations.".

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting "or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974," after "1954 of this title".

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

"SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

"The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.".

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

"SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

"The Secretary may, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such

person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1986, and regardless of whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).".

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

"Sec. 520. Applicability of State law to combat fraud and abuse.".

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURES ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

"SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

"(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

"(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under subsection (a) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

"(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under subsection (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

"(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order involved may be affirmed, modified, or set aside by the Secretary in whole or in part.

"(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

"(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

"(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).".

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 4302(a), is amended by adding at the end the following:

"TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

"SEC. 3201. PURPOSE.

"The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

"(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

"(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

"(3) alleviate burdens on family caregivers; and

"(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

"SEC. 3202. DEFINITIONS.

"In this title:

"(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

"(2) ACTIVELY EMPLOYED.—The term 'actively employed' means an individual who—

"(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

"(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

"(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(F) Continence.

"(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

"(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

"(6) ELIGIBLE BENEFICIARY.—

"(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

"(i) has paid premiums for enrollment in such program for at least 60 months;

"(ii) has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

"(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

"(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

"(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

"(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms 'hospital', 'nursing facility', 'intermediate care facility for the mentally retarded', and 'institution for mental diseases' have the meanings given such terms for purposes of Medicaid.

"(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term 'CLASS Independence Advisory Council' or 'Council' means the Advisory Council established under section 3207 to advise the Secretary.

"(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term 'CLASS Independence Benefit Plan' means the benefit plan developed and designated by the Secretary in accordance with section 3203.

"(10) CLASS INDEPENDENCE FUND.—The term 'CLASS Independence Fund' or 'Fund' means the fund established under section 3206.

"(11) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(12) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(13) PROTECTION AND ADVOCACY SYSTEM.—The term 'Protection and Advocacy System' means the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15043).

"SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

"(a) PROCESS FOR DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

"(A) PREMIUMS.—

"(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, subject to clauses (ii) and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

"(ii) NOMINAL PREMIUM FOR POOREST INDIVIDUALS AND FULL-TIME STUDENTS.—

"(I) IN GENERAL.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

"(aa) any individual whose income does not exceed the poverty line; and

"(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

"(II) APPLICABLE DOLLAR AMOUNT.—The applicable dollar amount described in this subclause is the amount equal to $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year occurring after 2009 and before such year.

"(iii) CLASS INDEPENDENCE FUND RESERVES.—At such time as the CLASS program has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS

program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

"(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

"(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

"(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

"(ii) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.

"(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

"(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

"(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

"(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

"(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

"(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

[*Subparagraph (E) stricken by section 10801(a)(1)(A)*]

"(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

"(A) evaluate the alternative benefit plans developed under paragraph (1); and

"(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

"(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the

CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

"(b) ADDITIONAL PREMIUM REQUIREMENTS.—

"(1) ADJUSTMENT OF PREMIUMS.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

"(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

"(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed).

"(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

"(I) has attained age 65;

"(II) has paid premiums for enrollment in the program for at least 20 years; and

"(III) is not actively employed.

"(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

"(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for reenrollment in the program. ⟦*As revised by section 10801(a)(1)(B)*⟧

"(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

"(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

"(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

"(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

"(E) PENALTY FOR REENOLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

"(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenollment is effective; or

"(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

"(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

"(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with subparagraphs (D) and (E) of paragraph (1)) shall be used to—

"(A) determine the monthly premium for enrollment in the CLASS program; or

"(B) prevent an individual from enrolling in the program.

"(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

"(1) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii) to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed; ⟦*As revised by section 10801(a)(1)(C)*⟧

"(2) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

"(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

"SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

"(a) AUTOMATIC ENROLLMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

"(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

"(A) who is self-employed;

"(B) who has more than 1 employer; or

"(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

"(3) ADMINISTRATION.—

"(A) IN GENERAL.—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

"(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

"(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

"(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual—

"(1) who has attained age 18;

"(2) who—

"(A) receives wages or income on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986; or ⟦*Replaced by section 10802(a)(2)(A)*⟧

"(B) derives self-employment income on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

"(3) who is actively employed; and

"(4) who is not—

"(A) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or

an institution for mental diseases and receiving medical assistance under Medicaid; or

"(B) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

"(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (A) or (B) of subsection (c)(2) in order to maintain enrollment in the CLASS program. ⟦*As revised by section 10801(a)(2)(B)*⟧

"(e) PAYMENT.—

"(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

"(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

"(A) who does not have an employer who elects to deduct and withhold premiums in accordance with paragraph (1); or ⟦*As revised by section 10801(a)(2)(C)*⟧

"(B) who does not earn wages or derive self-employment income.

"(f) TRANSFER OF PREMIUMS COLLECTED.—

"(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

"(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

"(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which—

"(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has not enrolled in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and ⟦*As revised by section 10801(a)(2)(D)*⟧

"(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during

an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

"SEC. 3205. BENEFITS.

"(a) DETERMINATION OF ELIGIBILITY.—

"(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

"(2) ELIGIBILITY ASSESSMENTS.—

"(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

"(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

"(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

"(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

"(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

"(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

"(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

"(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

"(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

"(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

"(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

"(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

"(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

"(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

"(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

"(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

"(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advise and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(3).

"(c) PAYMENT OF BENEFITS.—

"(1) LIFE INDEPENDENCE ACCOUNT.—

"(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

"(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

"(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

"(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

"(ii) allowing the beneficiary to access such account through debit cards; and

"(iii) accounting for withdrawals by the beneficiary from such account.

"(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible

beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

"(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

"(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

"(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

"(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

"(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

"(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

"(I) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act (42 U.S.C. 1396u–4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

"(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

"(2) AUTHORIZED REPRESENTATIVES.—

"(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

"(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

"(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

"(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

"(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

"(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

"(i) the total amount of the accrued deferred benefits; or

"(ii) the applicable annual benefit.

"(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

"(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the

first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

"(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

"(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

"(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

"(I) the death of a beneficiary; or

"(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

"(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

"(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

"(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

"(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

"(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

"(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

"(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

"(A) information regarding how to access the appeals process established for the program;

"(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

"(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

"(2) ensure that the System and such counselors comply with the requirements of subsection (h).

"(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

"(1) accessing and coordinating long-term services and supports in the most integrated setting;

"(2) possible eligibility for other benefits and services;

"(3) development of a service and support plan;

"(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

"(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

"(6) such other services as the Secretary, by regulation, may require.

"(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

"(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

"(h) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

"(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

"(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

"(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

"(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

"(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

"(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is

informed of any financial interest that the entity has in a service provider.

"(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

"SEC. 3206. CLASS INDEPENDENCE FUND.

"(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

"(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

"(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

"(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

"(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act (42 U.S.C. 1395t).

"(c) BOARD OF TRUSTEES.—

"(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

"(2) DUTIES.—

"(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

"(i) Hold the CLASS Independence Fund.

"(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

"(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i).

"(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

"(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

"(i) include—

"(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

"(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

"(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

"(IV) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

"(ii) be printed as a House document of the session of the Congress to which the report is made.

"(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

"SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

"(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

"(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

"(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

"(2) TERMS.—

"(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

"(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

"(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

"(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

"(1) the development of the CLASS Independence Benefit Plan under section 3203;

"(2) the determination of monthly premiums under such plan; and

"(3) the financial solvency of the program.

"(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

"(e) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

"(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

"SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

"(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS

Independence Advisory Council, for purposes of ensuring that enrollees premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3202.

"(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan. For purposes of this subsection, the term 'taxpayer funds' means any Federal funds from a source other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings.

"(c) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

"(d) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

"(1) The total number of enrollees in the program.

"(2) The total number of eligible beneficiaries during the fiscal year.

"(3) The total amount of cash benefits provided during the fiscal year.

"(4) A description of instances of fraud or abuse identified during the fiscal year.

"(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or to prevent the occurrence of fraud or abuse.

"SEC. 3209. INSPECTOR GENERAL'S REPORT.

"The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

"(1) The eligibility determination process.

"(2) The provision of cash benefits.

"(3) Quality assurance and protection against waste, fraud, and abuse.

"(4) Recouping of unpaid and accrued benefits.

"SEC. 3210. TAX TREATMENT OF PROGRAM.

"The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.".

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6505, is amended by inserting after paragraph (80) the following:

"(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under

the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and".

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (81) the following:

"(82) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

"(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

"(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

"(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.".

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) INCLUSION OF CLASS PROGRAM INFORMATION IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—[*As revised by section 10801(b)*] Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking "and" at the end;

(B) in clause (iii), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits. [*As revised by section 10801(c)*]"; and

(2) in paragraph (3), by striking "2010" and inserting "2015".

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) take effect on January 1, 2011.

(f) RULE OF CONSTRUCTION.—Nothing in this title or the amendments made by this title are intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

"(a) IMPOSITION OF TAX.—If—

"(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

"(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

"(b) EXCESS BENEFIT.—For purposes of this section—

"(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

SEC. 10603. STRIKING PROVISIONS RELATING TO INDIVIDUAL PROVIDER APPLICATION FEES [*AMENDMENTS FULLY INCORPORATED ABOVE*].

(a) [*Amended section 1866(j)(2)(C) of the Social Security Act, as added by section 6401(a)*]

(b) [*Replaced section 6401(a)(2)*]

SEC. 10604. TECHNICAL CORRECTION TO SECTION 6405 [*AMENDMENTS FULLY INCORPORATED ABOVE*].

[*Replaced paragraphs (1) and (2) of section 6405(b)*]

SEC. 10605. CERTAIN OTHER PROVIDERS PERMITTED TO CONDUCT FACE TO FACE ENCOUNTER FOR HOME HEALTH SERVICES [*AMENDMENTS FULLY INCORPORATED ABOVE*].

(a) [*Amended section 1814(a)(2)(C) of the Social Security Act, as amended by section 6407(a)(1)*]

(b) [*Amended section 1835(a)(2)(A)(iv) of the Social Security Act, as amended by section 6407(a)(2)*]

SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.

(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term "Federal health care offense" has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(2) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subsection, the United States Sentencing Commission shall—

(A) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(B) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(C) amend the Federal Sentencing Guidelines to provide—

(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000; and

(iv) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(3) REQUIREMENTS.—In carrying this subsection, the United States Sentencing Commission shall—

(A) ensure that the Federal Sentencing Guidelines and policy statements—

(i) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(ii) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(B) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in paragraph (2);

(C) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(D) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(E) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(F) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting "(a)" before "Whoever knowingly"; and

(2) by adding at the end the following:

"(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.".

(c) HEALTH CARE FRAUD OFFENSE.—Section 24(a) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semicolon and inserting "or section 1128B of the Social Security Act (42 U.S.C. 1320a–7b); or"; and

(2) in paragraph (2)—

(A) by inserting "1349," after "1343,"; and

(B) by inserting "section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131)," after "title,".

(d) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(1) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking "to the grand jury"; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking "grand jury subpoena" and inserting "subpoena for records"; and

(ii) in the matter following subparagraph (B), by striking "to the grand jury".

(2) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

"SEC. 3A. SUBPOENA AUTHORITY.

"(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

"(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

"(1) ISSUANCE.—Subpoenas issued under this section—

"(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

"(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

"(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

"(c) PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

"(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

"(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

"(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.".

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

(3) by inserting after clause (ii) the following:

"(iii) provides at least 40 percent of its services to individuals who are not eligible for benefits under this title; and".

(b) RESTRICTION.—Section 1861(ff)(3)(A) of such Act (42 U.S.C. 1395x(ff)(3)(A)) is amended by inserting "other than in an individual's home or in an inpatient or residential setting" before the period.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the first day of the first calendar quarter that begins at least 12 months after the date of the enactment of this Act.

SEC. 1302. MEDICARE PREPAYMENT MEDICAL REVIEW LIMITATIONS.

Section 1874A(h) of the Social Security Act (42 U.S.C. 1395w–3a(h)) is repealed.

SEC. 1303. FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.

(a) FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)), as amended by section 6402(i) of the Patient Protection and Affordable Care Act, is further amended—

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

"(8) ADDITIONAL FUNDING.—

"(A) IN GENERAL.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3)(C) and (4)(A) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated to such Account from such Trust Fund the following additional amounts:

"(i) For fiscal year 2011, $95,000,000.

"(ii) For fiscal year 2012, $55,000,000.

"(iii) For each of fiscal years 2013 and 2014, $30,000,000.

"(iv) For each of fiscal years 2015 and 2016, $20,000,000.

"(B) ALLOCATION.—The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended."; and

(B) in paragraph (4)(A), by inserting "for activities described in paragraph (3)(C) and" after "necessary".

(b) MEDICAID INTEGRITY PROGRAM.—Section 1936(e)(1) of such Act (42 U.S.C. 1396–u6(e)(1)) is amended—

(1) in subparagraph (B), by striking at the end "and";

(2) in subparagraph (C)—

(A) by striking "for each fiscal year thereafter" and inserting "for each of fiscal years 2009 and 2010"; and

(B) by striking the period and inserting "; and"; and

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

"(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.".

SEC. 1304. 90-DAY PERIOD OF ENHANCED OVERSIGHT FOR INITIAL CLAIMS OF DME SUPPLIERS [*AMENDMENT FULLY INCORPORATED INTO PPACA*].

[*Inserted new paragraph (4) in section 1866(j) of the Social Security Act, as amended by section 6401*]

Subtitle E—Provisions Relating to Revenue

SEC. 1401. HIGH-COST PLAN EXCISE TAX [*AMENDMENTS FULLY INCORPORATED INTO PPACA*].

(a) IN GENERAL.—Section 4980I of the Internal Revenue Code of 1986, as added by section 9001 of the Patient Protection and Affordable Care Act and amended by section 10901 of such Act, is amended—

(1) [*Added a clause (ii) to subsection (b)(3)(B)*]

(2) [*Amended subsection (b)(3)(C), including insertion of new clauses (ii) and (iii)*]

(3) [*Struck subparagraph (D) of subsection (b)(3)*]

(4) [*Inserted new clause (ii) in subsection (d)(1)(B)*]

(5) [*Added a paragraph (3) at end of subsection (d)*]

(b) EFFECTIVE DATES.—

(1) [*Amended section 9001(c) of PPACA*]

(2) [*Amended section 10901(c) of PPACA*]

SEC. 1402. UNEARNED INCOME MEDICARE CONTRIBUTION.

(a) INVESTMENT INCOME.—

(1) IN GENERAL.—Subtitle A of the Internal Revenue Code of 1986 is amended by inserting after chapter 2 the following new chapter:

"CHAPTER 2A—UNEARNED INCOME MEDICARE CONTRIBUTION

"Sec. 1411. Imposition of tax.

"SEC. 1411. IMPOSITION OF TAX.

"(a) IN GENERAL.—Except as provided in subsection (e)—

"(1) APPLICATION TO INDIVIDUALS.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax equal to 3.8 percent of the lesser of—

"(A) net investment income for such taxable year, or

"(B) the excess (if any) of—

"(i) the modified adjusted gross income for such taxable year, over

"(ii) the threshold amount.

"(2) APPLICATION TO ESTATES AND TRUSTS.—In the case of an estate or trust, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax of 3.8 percent of the lesser of—

"(A) the undistributed net investment income for such taxable year, or

"(B) the excess (if any) of—

"(i) the adjusted gross income (as defined in section 67(e)) for such taxable year, over